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‘Futile’ orders and morally distressed nurses:  
Professionally sanctioned conscientious  
objection is not the solution.

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## Doctors' orders and morally distressed nurses: an objection to conscientious objection as a resolution.

There are differing views on the exact nature of moral distress in nursing, but essentially, most empirical work indicates that it is the nurse's inability to do the right thing because she feels impeded from doing so, due to constraints such as organisational structures or lack of authority in medical decision making.

This thesis will begin with a philosophical analysis of the meaning of moral distress. It will be argued that it is a poorly defined concept but that even so, the emotional and rational challenges that it brings to the nurse, are valid and worthy of more exploration.

It will be argued that moral distress is more or less synonymous with 'troubled conscience'. Thereafter Catlin et al's (2008) claim that the nursing profession ought to sanction conscientious objection to doctors' orders when nurses are morally distressed by perceived futile care will be examined.

I will oppose this position, and argue that instead, nurses can limit their sense of responsibility for actions performed on the behalf of doctors. To defend my position will require the construction of arguments based on current legal and professional practice and philosophical concepts such as erroneous conscience, moral luck and the ethics of care.

In seeking to defend my alternate view of how the nursing profession ought to behave under such circumstances, I will propose a new resolution to moral distress. This will involve ethical reasoning that includes consequentialist justifications within the paradigm of the ethics of care. It will also involve addressing the emotional and spiritual challenges of nursing care, which I will argue have so far not been recognised as significant components of moral distress.

Catlin A, Volat D, Hadley M., Bassir R., Armigo C., Valle E., Gong W. and Anderson K. (2008) Conscientious Objection: A Potential Neonatal Nursing Response to Care Orders That Cause Suffering at the End of Life? Study of a Concept. *Research in Nursing* 27 (2) p. 101 – 108.

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### Notes on text

Throughout this work, to prevent confusion, 'he' will refer to the doctor and 'she' to the nurse.

'Futile' care will be referred to where the nurse (or other) perceives medical treatment to be overly aggressive. This contrasts with futile care, where medical treatment is agreed by consensus or medical opinion to be against the best interests of the patient because it is known that no improvement will be made. It should be noted that 'care' refers to medical intervention, not nursing care, which is rarely if ever futile.

In chapters one and two 'moral distress' will refer to the term as it is commonly understood.

In chapters three – seven, 'moral distress' will mostly used to define the form of moral distress that this thesis takes as its subject; that is moral distress that arises from being asked to perform 'futile' orders.

For ease of reference, ethically challenging situations will be referred to as 'ethical dilemmas' even though most are not strictly speaking ethical dilemmas.

## Abbreviations

AACN	American Association of Critical Care Nurses
ACOG	American College of Obstetricians and Gynaecologists
AMA	American Medical Association
ANA	American Nursing Association
GPC	General Pharmaceutical Council
ICN	International Council of Nurses
ICU	Intensive Care Unit
NMC	Nursing and Midwifery Council (UK)
US	United States of America

## Prologue

The subject chosen for this thesis is grounded in clinical experience and has been written about by philosophical and empirical researchers since the early 1980s. It will address the experience of moral distress. As Wilkinson (1987) points out, nurses who experience moral distress are sincere, thoughtful and credible practitioners who are aware of the moral issues of their practice.

There is a problem with moral distress that Nathaniel (2006) points out; that is that the objective bystander doesn't necessarily see any ethical issue that needs to be addressed. Indeed when the narrative that the reader will soon come to, was submitted to a peer-reviewed journal, the reviewers initially could not see beyond an emotionally distressing incident. As shall be seen, there are a number of ethical questions that need to be answered in order to reach normative conclusions about how nurses ought to respond to moral distress, and specifically for this thesis, how they ought to respond to medical orders that they identify as harmful to their patients.

This work will be grounded in my own experience of nursing and will involve some reflexive analysis of the personal experience of moral distress in the narrative that is to follow. Chambon & Irving (2003) argue that once ethics enters into the world of experience and especially suffering, that reason seems fragile in its persistence to render everything under coherent argument. To some extent this will be true for this work.



As an alternative choice, I could have looked into whether or not medically aggressive care is justifiable or not, when it is known that some will suffer in the meeting of this end. Such a stance would have led to more easily defined and articulated arguments than the subject I have chosen.

The subject of this thesis does include consideration of the ethics of aggressive medical treatment. However, the prime focus will be the moral distress that the nurse experiences under these treatment orders. This is a nebulous cloud of emotional and articulated responses within which wrong-doing may or may not be found to be present.

This prologue will begin with the autobiographical narrative 'Grim orders and fragile birds' which sets the scene for what will follow. Indeed it could almost stand by itself. However, before entering into the chapters that follow, a brief summary will be given about how this thesis will be structured.

#### Grim orders and fragile birds.<sup>1</sup>

It is the year 2000 and I want you to imagine a ward of patients. You are in a nurse's uniform. You are young and junior. Your name badge announces you as 'Staff Nurse'. There are bays along the length of the ward, each housing eight patients, most with small machines by their beds that will spew clouds of medicine via facemasks. Just now the machines are quiet. But wait until the drugs round, and one by one they'll waken, the sound of clapped out motors reaching a crescendo, until one by one the patients turn them off. The ward is

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<sup>1</sup> This narrative has been published. (Walsh, 2010)

full. Patients sit. Some wander. Others lie in side rooms with half closed doors. In one of the bays, sitting in the corner is an old lady. Her hair is curly grey. The nightdress she wears gapes about her chest. Its shoulders appear to hang off a coat hanger. The sleeves are billowy; almost sail like, with skinny arms flapping between. The fabric that used to fit now serves as a frame that draws attention to the skeletal body that the woman has come to inhabit. The flesh on her face has collapsed into the shape of a skull. Her dentures rattle and dance when she speaks. Her eyes are bright blue. They shine and dart from side to side until you approach, sit, and touch her to gain her attention. There's something bird like about her. Let's call her Mrs Bird.

Her eyes settle and rest into yours. The tubing snaking from the wall, across her bare ribs, around her ears and nose delivers oxygen. Carbon dioxide drenches her blood and so not too much oxygen, or she will stop breathing. No, breathing isn't quite the right word. Panting. She pants, and has done for years.

You touch her hand. Her fingers are cold, her nails are a wave of blue that curve over her finger tips. Her lips have a blue hue. The oxygen helps to keep her alive. Alive enough to eat tiny portions of food. Alive enough to have an echo of recognition when she sees her son visit. Alive enough to have a sense that there are things to do. Alive enough to feel the oxygen tubing pulling at her face when she gets up to see to her jobs. Alive enough in her low oxygen state, to have the sense - in the midst of her confusion - to take the tubing off and wander in pursuit of what exists in her thoughts. Alive enough to feel your hand and to be comforted by it.

The doctors do their round and take note that you have seen her condition deteriorate. This is her third admission in two months. Her stiffened lungs are not responding to the antibiotics and steroids that will clear infection and reduce inflammation.

At the end of the round the charge nurse approaches. He tells you that Mrs Bird is to have a doxapram infusion. Doxapram. You feel your chest tighten. It's a drug that makes patients breathe harder. It makes their muscles tremble. They don't sleep. They are agitated. The last gravely ill person you managed on this drug was like a hunted fox. What about her steroids? Are they increasing the dose? Are they going to change her antibiotics? No, just doxapram.

You begin to argue. What is the point of giving doxapram without treating any underlying condition? She wouldn't be ventilated, so why make her self ventilate? With no hope of alleviating underlying conditions she will self ventilate and most likely die on the drug.

Your primary nurse arrives. The sentence 'we don't commit euthanasia' is spoken. Next comes the junior doctor. You explain what is wrong. He takes you to the desk and draws a picture to show you how doxapram works on breathing rate and depth. You have a sudden flash of anger and feel like slapping him. You've worked in intensive care and so you slap him with this information instead. He apologises. Still no one 'gets' it until the registrar arrives. You speak to him. He listens. He says he thinks you are right. There is a moment of relief; at

least you have been heard. But he continues, that the consultant is now gone and the team will follow his plan. Then comes desperation; nothing will change. You are not the person who can alter the course of medical treatment. You have argued your case. You have taken it to the highest level. You have been understood. But the senior doctor makes the decision.

So stop. Take in what has happened so far. Touch the smooth steel of the artery forceps in your breast pocket. You have spent the morning helping patients to wash and to clamber onto the commode. The Irish patient has joked with his fellow inmates that you are 'the flasher', you having woken him a few nights ago with your torch shining in his face to make sure that he wasn't dead. He wasn't dead, but the shock of waking to the bright light and you looming anxiously over him almost killed him. You have travelled to and from the sluice to dispose of urine and faeces and then pushed the drugs trolley from bed to bed. You have informed relatives of a patient's death and laid out the body ready for their arrival. Next door another patient is dying. You have cleaned his mouth and turned him. As is the case with every early shift, you sweat. Mrs Bird is looking out of the window, the fan that helps her feel more able to breathe, blowing a breeze into her face.

The charge nurse sees that you are visibly distressed. Academics would state 'morally distressed.' It's the distress you feel because you believe you know the right action to take, but are not able to carry it out. He touches your arm – you will not forget his compassion. He tells you he can see how upset you are, that it

is ok and he offers to put up the infusion for you. You have been offered the opportunity to conscientiously object to carrying out a medical treatment.

Let the ward lights dim. Let the scene fade to darkness. Let yourself take centre stage. Let the spotlight shine on you. It is time to examine your conscience. You have been asked to perform an action. You believe that the action is wrong. Most likely it is wrong. You have the opportunity to remove yourself from that action. Your charge nurse will assemble the equipment, prepare the infusion and attach it to Mrs Bird. He will set the rate and press the start button. Your 'hands' will be clean. Such a simple answer to the situation. Your distress will ease. Your autonomy and integrity will be protected. But is this the right thing to do? Ought you to be the focus? What about Mrs Bird? What about the other patients?

What does it mean to be their nurse and where does your responsibility lie? Most importantly where does your responsibility end? And when you define its limits – if you exchange some autonomy for some humility - does it free you of a burden in order to do something else?

The dying patient in the side room needs to be turned again. His mouth is dry. It is time to soak a sponge in water and then rest it in his mouth. He appears unconscious but will furiously suck when the sponge touches his tongue. Such matters are the responsibility of nurses. Tedious, repetitive and physically demanding labour that eases suffering and that literally protects patients' bodies from decay.

Your code of conduct does not allow you to conscientiously object to carrying out medical treatment, or dare I go as far as to say 'carry out a doctor's orders'? Academics tend to focus on your distress and your powerlessness. They wish to promote your professional autonomy. The solution is to alleviate it with empathic workshops, ethics rounds and egalitarian collaboration between health care teams. They concentrate their research in hospices and intensive care units where funding and staff can accommodate grand ideology and where 'ethical dilemmas are a theatre advertised in neon lights. But this is a busy medical ward. Mrs Bird is getting up. She pulls at her nightdress. You need to make sure that she does not wet herself. That she sits down before she falls.

There is an error made in medical ethics when your moral distress and lack of autonomy becomes the focus of research and attention. There is more to this scene than meets the eye of many ethicists. You are a nurse. You can engage in what is seen to be lofty debate about the rightness of medical intervention and indeed I do not want to suggest that you ought not to have argued the case against doxapram. An opiate would have eased her. However, don't forget that the important person is Mrs Bird. It is not you. Whilst you discuss and distress about whether or not she should have the drug, whether or not you put up the infusion or who else can do it if you don't, Mrs Bird is thirsty. She has been sat too long on the chair and the skin on her buttocks will start to peel. She hasn't passed faeces for three days and is feeling bloated. Is thirst or constipation any less of a distressing symptom than side effects of a drug? Is it less deserving of attention?

Take yourself to the medicine room. Prepare the infusion. Accept that you now perform an action for which you can limit what you are responsible for. It is the doctor who has prescribed the medication. It is the doctor who has refused to alter the course of treatment despite his agreement with you that it is not the best treatment to proceed with. This is not murder, it is at worst a bad medical decision, but who knows what might happen next? The odds are that Mrs Bird will die, but remember you deal in odds and they are not a certainty. Accept that at worst Mrs Bird will most likely suffer side effects that will distress her and that in a better world she would not be receiving this drug. Accept that in a better world she would not suffer respiratory failure. Accept that in this world you can only do your best under the circumstances. Limit what you are responsible for - you will be responsible for making sure that the drug is at the correct dosage, that it will infuse correctly and safely and that you will watch her closely for the coming hours.

Know that you have an obligation to free yourself from the burden of the sense of responsibility that it is you who will cause her to suffer when you start the infusion. Know that in freeing yourself from this burden you will be free to do something else for your patient. You will be free to feel compassion. You will be free to consider her needs rather than your own. You will be free to nurse her – to remain close rather than avoid her, to walk with her whatever path unfolds. This is the essence of nursing – to remain with the patient and walk with them every step of the way; to remain with the patient when all the other professionals walk out of the door.

It is time to bring the medication to Mrs. Bird's bedside. You push the infusion pump to her bedside. You sit. You touch her hand. You explain that the doctors have decided to give her some medicine. You tell her that it will help with her breathing. You tell her that you will keep an eye on her. She looks into your eyes and for a little while looks peaceful. It is not long before you see the tremors start in her hands.

The act is done. You have made the decision to set up the infusion for your patient despite the charge nurse offering to do it for you. At the time you believed that you ought to follow your code of conduct, and carry out your duty to follow prescribed medical treatment.

You went home that evening feeling defeated and with the emotional strain of having felt that you had done something in a caring manner that was wrong. You felt duplicitous. I wish, watching you ten years after the event, that your ethical reasoning had extended beyond your code of conduct duties and the sense of loss of integrity that resulted. If only you had had the humility to limit your sense of responsibility and in so doing that you had freed yourself to concentrate on nursing care. If only you hadn't have felt inclined to take flight from Mrs Bird, as the researchers have found happens, because all you could see was the wrongdoing of the medical intervention and your own complicity in causing that harm.

If only you had also realised something else. That we are limited by the point of history with in which the stories of our lives are told. Today palliative care teams are involved with patients such as Mrs Bird. The limitations in her care were as



much a reflection of the times in which she was sick, as a reflection on the characters who crossed her path during her hospital stay. I wish that you had realised that your experience with Mrs Bird would extend throughout your career in positive ways. The event that made you consider the importance of the labour of nursing and the importance that this labour be recognised as worthy of academic discourse in circles more inclined to concentrate on the dilemmas of medicine and science.

But the present tense does not have the benefit of hindsight. It is time to return to the year 2000. You are in nurse's uniform. Your name badge announces you as 'staff nurse'. You arrive in the ward the next morning. At handover you ask how Mrs Bird has fared overnight. You are told that she died in the early hours with the doxapram infusion running. You know she had struggled for the last hours of her life. There had been no palliation of her symptoms. Although her death was more difficult than it need to have been, she had been warm, she had not been thirsty and she had been cared for. As the dawn begins to break the junior doctor, who was on call all night, discusses the coming ward round with the charge nurse. The registrar is at home rising from his bed. The patients begin to switch on the machines by their beds, the sound of clapped out motors rising and filling the air. It is time to go and lay out Mrs Bird's body in readiness to greet her son. He will be coming to pay his last respects soon.

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The thesis will be structured as follows. In chapters one and two the nature of moral distress will be examined and the question of whether or not it can be

considered a valid source for the identification of wrong-doing will be identified. In chapter three, the relationship between moral distress, conscience and conscientious objection will be demonstrated. Conscientious objection to overly aggressive medical orders will be examined as a response to moral distress and an initial analysis of whether or not this position is supportable for nurses, will be made. In chapters four, five and six it will be argued that conscientious objection by nurses in response to overly aggressive medical orders is not supportable when philosophy, law and professional codes of conduct are examined respectively. Finally in chapter seven the most serious objection to the arguments presented in chapters four to six will be described and refuted. Finally, alternative resolutions to moral distress will be suggested. In the epilogue the original narrative will be returned to, in a final analysis to identify if the arguments that were initially made have withstood more intensive research.

## Chapter One: *Moral distress*

### Introduction

This chapter will review and analyse the empirical work that has been carried out on moral distress. The way in which moral distress is understood will be presented, followed by an examination of why it is a significant issue for nursing practice. It will be shown that the harm that moral distress is understood to be is caused by three potential sources of wrong-doing. Firstly, there is an assumption that primary harm is done to the patient. Secondly, there is a secondary harm. This harm is a harm experienced directly by nurses or that indirectly effects the patient through harm that the nurse experiences.

It will be shown that researchers tend to identify a primary harm, but then tend to address the secondary harm and not the primary harm when they suggest resolutions to ease moral distress. In other words, although researchers identify primary harm to the patient, in the introduction to their work, the sense of the nature of harm alters as normative conclusions are presented.

### Moral Distress: Definitions

There are two definitions of moral distress that are most commonly cited by empirical researchers and these have been provided by Jameton (1984) and Nathaniel (2003). Jameton (1984) was the first person to define the experience as a specific concept. He defined it as the feelings and experiences that result from a moral conflict where one knows

‘the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action’ (p. 6).

Wilkinson (1987, p16) at around the same time, and taking up Jameton’s ideas, defined it as:

‘the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision’. (p.16)

A later refinement of this definition has been offered by Nathaniel (2003) who described it as:

‘the pain or anguish effecting the mind, body or relationships in response to a situation where a person is aware of the moral problem, acknowledges personal responsibility and makes a moral judgment about the correct action, yet as a result of real or perceived constraints participates in perceived moral wrongdoing.’ (p22)

Moral distress has been accepted as a valid term by the American Association of Critical Care Nursing (AACN, 2010) and it has a validated tool for measurement (Corley et al., 2001). Studies indicate that between around thirty (Redmond and Fry 2000) and fifty (Rushton and Scanlon, 1995) percent of nurses have experienced it.

Further to these definitions it can be subdivided into two forms. Firstly, there is 'moral distress' that occurs at the time of the incident. Depending on how the incident is resolved, moral distress might be resolved or eased, or else it may become 'reactive moral distress', where the situation is not resolved, and a residue of the emotions continue, despite passage of time (Wilkinson, 1987).

The common ground that Jameton and Nathaniel share, clearly indicates that the term 'moral distress' can with certainty, be taken as an emotional response to a morally charged situation. In addition to this, a sense of responsibility is specified in the second, and can be inferred from the first, given that Jameton refers to the sense of a need to act: when one decides upon an action, responsibility for that action necessarily lies with the person who decides to cause an act to occur. However, there is a point of difference between both definitions. Nathaniel departs from Jameton when he uses the word 'perceived' in reference to the constraints and wrong-doing<sup>2</sup> that the nurse feels she participates in. Unlike Jameton, Nathaniel includes the insinuation, that the nurse is not always correct in her identification of constraints, nor in her identification of wrong-doing. This nuance is an important factor to elucidate, that is, does moral distress identify harm to patients and if so, what is the nature of that harm and what can nurses do about it? The second question that requires attention is that should it be found that it does not identify moral harm to patients, then what else does it indicate, and in that case what ought to be done?

Most authors, whichever definition they initially refer to, either explicitly or implicitly include an assumption that moral distress arises from an initial act of

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<sup>2</sup> Wrong-doing is synonymous with an act of harm to the patient

harm to patients<sup>3</sup>. For example, Austin et al. (2005) state that nurses experience moral distress when

‘the choice for the good is quite clear, but the implementation of the morally acceptable action is thwarted.’(p34)

Epstein and Delgado (2010) and Payne (2011) refer to moral distress, as knowing the right thing to do, and Payne goes so far as to state that the constraints to action are what are perceived, or psychologically constructed and not the harm that was initially identified.

This initial act of wrong-doing can be perceived as directly involving the patient, such as aggressive medical treatment (Elpern et al., 2005; Rice et al., 2008) or relate to issues such as lack of proper resources (Harrowing & Mill, 2010). This is the ‘primary harm’ or ‘primary wrong-doing’ that moral distress describes.

Authors who empirically research and describe the experience of moral distress identify primary harm but then tend to ‘leap’ from the description of moral distress to normative statements about other forms of harm, that is the secondary harms done to the nurse and indirectly the patient, and then discuss how it ought to be resolved. Most commonly, the resolution addresses the secondary harm, although as shall be seen, Catlin et al. (2008) in her study on conscientious objection, concedes to and addresses the primary harm that is perceived to be done to the patient. This finding that an ethical analysis of the nature of harm and what ought to be done about it is missing from the empirical literature is supported by Repenshek (2009) who argues that moral distress is a

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<sup>3</sup> Or patient.

case of mistaken identity, where the nurse misidentifies moral uncertainty for certainty. Nathaniel (2003) also supports the position that the differences in opinion that arise in moral distress do not arise from actual harm.

#### Particular and contextual causes of moral distress.

Moral distress is caused by a number of states of affairs that can be divided in to two. Firstly there are the particular causes that are associated with primary harm. Secondly there are contextual causes that are associated with secondary harm.

Particular causes of moral distress are the incidents that directly effect the patient or patients, and that cause the experience of moral distress in a particular nurse in a particular circumstance. Nurses have been shown to identify many practices as causative of moral distress. These causes are varied, but include for example, doctors giving overly optimistic prognoses to patients or families, (Ferral, 2006) families pushing for treatment to continue where prognosis is poor, (Ferral, 2006) aggressive medical care which means that patients do not die well, (Corley, 1995; Elpern et al., 2005; Ferral, 2006, Hamrick & Blackhall, 2007), working at perceived unsafe staff levels (Rodney & Starkomski, 1993; Austin et al., 2005; Ohnishi et al., 2010) and performing tests or procedures that were judged unnecessary (Zuzelo, 2007). Of these potential sources of moral distress, the participation in cases of aggressive medical treatment where survival is unlikely – in other words participation in acts that are described, not quite literally accurately, as ‘medically futile’, have been consistently reported as

causing the most acute and distressing symptoms of moral distress.<sup>4</sup>  
(Beckstrand & Kirchhoff, 2005; Meltzer & Hckabay, 2004; Ferrell, 2006)

With contextual external causes of moral distress, some authors ground these particular external causes in a broader sociological context. There appear to be broadly two frameworks that contextualise these causes of moral distress. Both of these frameworks overlap and are associated with the secondary harm identified in moral distress.

Firstly, authors identify a power imbalance as the ground within which moral distress arises. For example, some authors refer to a power imbalance, where nurses are given lots of responsibility and little authority (Pendry 2007) or as Sundin-Huard and fahy (1999) state, nurses have roles that convey more responsibilities than rights to correct the mistakes of doctors or managers. Austin et al. (2005) cite the seniority of doctors as a cause. Corley (1995), an author who has written extensively in the field of moral distress, states her case strongly, identifying that nurses are subservient to two masters: the organisation that pays their salary and the physicians who direct their care. Some authors take a specifically feminist approach to this issue, for example Erlin (2001) identifies the prime cause of moral distress as being fundamentally caused by the imbalance of power between nurses and doctors and that it links to gender roles, where deference to the doctor is expected and where the professional autonomy of the nurse is violated. The nurse might as a result of this imbalance, particularly when she disagrees with a plan of care, become submissive and only

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<sup>4</sup> I will refer to 'futile' care from now on to indicate aggressive medical care that appears to be overly aggressive and that does not allow the patient to die in the eyes of nurses, with peace and dignity.



do for the patient what is necessary. Jameton (1984, p37) argues that nurses have a history that was submissive and subservient to both physicians and institutions, which was not overthrown until the 1970s and the birth of feminism.<sup>56</sup> Presumably despite this 'overthrow' some of the same continues. Mathes (2004) argues that nurses don't demonstrate autonomy of thought due to this subservience to doctors and institutions and Austin et al. (2005a) argue that moral distress is a result of this relational aspect of nursing.

Secondly, other authors identify a conflict between the values and goals of medicine *versus* nursing. For example, Gutierrez (2005) identifies a conflict between nursing and medicine, where the purpose and values of each can be in opposition to one another; put simply one to care, the other to cure. It could be that these individual goals might result from different ethical frameworks: perhaps doctors tend to have a consequential view where the goodness of survival of the few is valued, whereas nurses take a more agent centred view of morality, where the wrongness of causing harm to the individual who is treated but dies, is more apparent. Some support for this conflict in perspective is offered by Elder et al. (2003) who found that nurses and medical students judged ethical situations differently. Nurses tended to take the perspective of the patient and argued from this point in an advocacy style whilst medical students tended to identify more with the profession of medicine.

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<sup>5</sup> Examples of such subservience can be found in Fagin & Garelick (2004) where quotes from the early 1900s demonstrate at least some doctors' views of nurses' place in the hierarchy.

<sup>6</sup> Olsen (1996) offers another feminist historical perspective on this issue, concentrating on professionalisation of nursing.

Furthermore, it is interesting to note that Gronlund et al.'s (2011) study found that physicians experience decision-making in the field of nephrology, as a weighing up of the lesser of two evils. This contrasts with nurses who seem to feel more certain about right and wrong when they experience moral distress. This may all add up to demonstrate another conflict or difference between nursing and medicine; that is the difference between carrying the full weight of responsibility for decisions as opposed to being in part an observer and participant in those decisions. This isn't only a restatement of previous discussion. It highlights that the decisions one might reach may be founded in the amount of responsibility or authority one carries. By this I mean that the nurse who doesn't carry full responsibility might be able to more readily prefer the outcome of death than suffering because the loss of that life won't lie in and 'dirty' her 'hands'.

The stance on conflicting goals (or conflicting moral frameworks) is supported by Fowler (1989), who found that nurses were in moral distress when they felt their desire to provide compassionate care, was impossible due to their intense involvement with life prolonging treatments, that required them to spend time managing medicines and observations rather than to concentrate on comforting actions. Sundin – Huard and Fahy (1999, p11) in their phenomenological study of moral distress support this position of contradictory perceptions and echo the emotions that are expressed in my narrative. They describe how nurses in 'futile' situations felt that they were participating in actions that were demeaning to the dignity of the patient and that bordered on 'abusing the body that just has no more life' in it. (p11). Added to this was the frustration of not being able to do

nursing work that they found to be fulfilling; that is helping a patient and family through the dying process.

Nathaniel (2006) who is the only writer to specify that nurses who felt moral distress had not participated in actual moral wrong-doing in keeping with her definition, describes how nurses felt a strong sense of responsibility for patients and took seriously the implicit promise to ease their suffering. She describes other causal factors of moral distress in relation to this sense of responsibility, for example times when on-call physicians refused to come in to see a patient at a nurse's request, refusals to order emergency medication or refusals to believe a nurse's evaluation of a patient's condition. Nathaniel in this paper agrees with the power imbalance between nurses and doctors, but rather than accepting this as an opportunity for a battle between right and wrong, she states it is an

'asymmetrical power relationship(s)...when there is no frank moral wrong-doing but rather divergent core beliefs' (p88 )

There is a third sociological context that has received attention but that is dissimilar to the previous two I have discussed. Interestingly, a minority of authors who have written on moral distress, identify proximity to the patient as a contextual cause (Torguul & Sorlie, 2006; Peter & Llaschenko, 2004). Nursing is a labour intensive activity that requires the physical proximity of the nurse, hour by hour, and shift by shift, to meet the ongoing physical and psychological needs of patients. Unlike other professional groups, the nurse does not leave the ward nor does she leave her relatively small group of patients, and in the case of intensive care, she does not leave her single patient's bed, except of course for

short breaks. The nurse by the nature of her work has intimate involvement with suffering; both the suffering caused by disease, but also the suffering caused by medicine. She not only observes but also, smells and metaphorically speaking touches such suffering, such as faecal incontinence or the excoriation mouth and skin. She hears the groans of patients as she turns a patient who appears to everyone else to be comatose. This proximity gives the nurse a perspective that is unique and that is in and of itself, distressing. (Ferrall & Coyle, 2008)

These three sociological contexts reflect my narrative. The nurse was in close proximity to a suffering patient, where the patient's suffering seemed not only pointless, but was also exacerbated by my medical colleagues and their prescribed treatment. Her proximity to other patients who had had doxapram meant that she had observed its unpleasant side effects. Her memory of another patient who had died on the drug, one who had been frightened and breathless, whose sweat marked her uniform with its smell as she made failed attempts to make him comfortable, added to her fears of what was to come. She wanted to ease Mrs Bird's suffering, not increase it. As the clash of medical and nursing values has described, the nurse's perspective clashed with that of the consultant: he saw an opportunity to possibly prolong her life whilst she saw fruitless suffering to come. And finally, the power imbalance; in the face of the senior registrar's decision, the nurse had no authority to over rule the medical decision.

#### Internal constraints and moral distress.

As well as external constraints, researchers describe constraints that arise within the individual who experiences moral distress. These are described as factors

such as fear of job loss, doubt, (Austin et al., 2005, Wilkinson 1987) and lack of courage (Lachman 2007, Murray 2010). Presumably such fears could prevent the nurse from acting as an advocate for her patient, although in my own narrative the nurse did not feel constrained from being able to do at least this.

### The 'epidemiology' of moral distress

Most research is focused in critical care, and as has been stated, moral distress has been found to be at its most extreme in cases of aggressive medical care that are perceived to be 'futile' on the part of nurses. However, it has also been described across different specialities in nursing; in paediatrics, (Janvier et al. 2007, Austin et al. 2009) military nursing (Fry et al., 2002; angelica et al., 2009), psychiatry (Austin et al., 2005b, Austin et al., 2007), care of the elderly (van der Dam et al., 2011) and in nurse practitioners working in the community in America (Laabs, 2005).

Interestingly, nurse practitioners were found to be different than other groups. Although they did suffer moral distress in relation to for example, not being able to get the necessary insurance to pay for care, their distress was less extreme than in other groups of nurses and was not identified by the nurse practitioners as a problem. The authors surmised that this was due to the greater autonomy of such nurses. Alternatively it might indicate that emotional reactions to situations are not to be fully trusted; the lack of care for patients who do not have insurance is not necessarily a greater moral wrong than for patients who undergo treatment that after the event of death has been proven as futile.

A minority of papers, describe moral distress in professional groups other than nurses. In 2007 Austin et al. reported that psychiatrists experienced moral distress when providing medical care for patients whilst at the same time safeguarding society as is required in law. In this instance they experienced conflict of interest in relation to balancing both of these factors. They felt that the law curbed their freedom in making autonomous medical decisions about the risks of giving potentially dangerous patients freedom in society. Hamrick and Blackhall (2007) found that doctors experienced moral distress in ICU but that nurses experienced a greater degree of distress than doctors when faced with similar 'futile' situations.

Kalvermark et al. (2005; 2006) described moral distress in pharmacists, where high levels of distress were experienced when dispensation of medication was prioritized for the patient who shouted the loudest rather than in the order of queuing or need. Brown and Gillespie (1999) identified it in university lecturers and Iglesias et al. (2010) investigated the experience in podiatrists. Finally, it is interesting to note that moral distress in physiotherapists was reported as being caused by observing poor nursing practice (Barnitt, 1998). Here it seems the power imbalance is expressed in the physiotherapists' position that does not authorise them to influence nursing practice. It also indicates that moral distress might also reflect the position of observer. In other words, it is easier to identify what may be wrong-doing in another professional group than one's own.

### Effects of Moral Distress.

That moral distress is a significant phenomenon in health care provision is supported by the literature. Fowler (1989) suggested that chronic reactive distress contributes to burnout and it has been found that nurses who have suffered moral distress are more likely to move their work position or to leave nursing altogether (Nathaniel 2006). Hamrick and Blackhall (2007) in their study of both nurses and doctors in ICU, found that although both professions experienced moral distress, it was only the nurses who would think about or had left a post due to this. Sundin-Huard and Fahy,(1999) found that fifteen percent of the nurses interviewed had left a previous position because of moral distress. Although not quantified, this results in costs to the health care system, either through loss of staff, or from movement of staff from areas such as ICU, with high investment in training, to other areas where that training is no longer put into practice.

Further in support of the difference between nurses and doctors Aase et al. (2008) in their qualitative study on the existential aspects of cardiac medicine, describe the stress of medicine for doctors, such as burnout, grief and emotional distress at seeing suffering, but found that more experienced doctors could keep the distress of exposure to suffering at a distance. This may well reflect not only development of coping mechanisms, but also the fact that with increased seniority doctors are less proximate to patients. Interestingly, the study also found that doctors found the responsibility of decision-making rewarding: an aspect of the work that is a stark contrast to nurses who for example, reported

that a major regret in their care was the lack of dialogue between the team (Sorlie et al., 2003). Of course as well as being rewarding, doctors can experience the responsibility for decision-making a burden that leads to them feeling undervalued, accused and unsupported in their decision-making (Gronlund et al., 2011). Ironically, not only does conflict exist between the goals of nursing and medicine, but conflict also exists in matters of coping with ethically difficult situations. The very wish of nurses for dialogue might for doctors be an experience of having one's authority undermined.

Nathaniel (2006) and Davies et al. (1996) describe how nurses who experience moral distress will distance themselves from patients, becoming either emotionally unavailable or physically avoiding patients rooms. Austin et al. (2009) found that nurses will often employ a mechanism to reduce the sense of distress by detachment of emotional engagement with the patient and situation, and instead concentrate on the technical tasks in hand. This emotional detachment is perhaps similar to that which was found to be employed by vets who have to treat and kill animals in a variety of different circumstances, some of which are morally challenging (Manette, 2004). Manette argues that to employ such devices is to deny one's sense of humanity, a sense that could also apply to nurses.

Nathaniel (2006) describes the emotional response as being the feeling of being sad, guilty, angry, a sense of powerlessness, internal conflict, depression, outrage and a sense of betrayal. The experience is also visceral. Nurses could experience near syncope, crying, sleeplessness and vomiting (Fenton 1988; Anderson, 1990; Ewing and Carter 2004; Nathaniel; 2006). or described their experience as 'gut



wrenching' (Hanna, 2005). Although most authors describe moral distress as a negative experience and an objectively negative event, Nathaniel's study stands out because contrary to the trend, he describes that nurses reported that their nursing care was improved as a result of moral distress because they felt compelled to make up for what they considered to be wrong-doing by giving more compassionate care and trying to treat the patient with dignity. In other words, using Manette's stance, the challenge of moral distress, where the nurse makes more effort to deliver a high standard of nursing care, might actually result in an increased sense of humanity or compassion.

My narrative reflects both of these contradictory positions. Once the infusion for Mrs Bird had been set up, the distressed emotional state of the nurse led her to avoid spending any more time with her than was necessary. However, the experience also had positive effects in so far as the nurse concluded that in the future she could instead alleviate her negative emotional state in a positive direction by being more compassionate. Indeed this response to care more, was also found by Yoder (2008) who studied nurses and compassion fatigue; she found that nurses who were faced with traumatic circumstances either chose to go onto 'autopilot' or else to engage more fully with patients and families.

The intensity of the moral distress response has been found by some to increase with age of the nurse Elpern et al., (2005) found that in situations of 'medical futility', that older nurses felt a more acute response than younger nurses. Torjuul & Sorlie (2006) and Rice et al. (2008) found that moral distress increased in the more experienced nurses. These findings are echoed by Schwenzer & Wang (2006) who investigated the incidence of moral distress in

respiratory therapists, and found that the greatest degree of distress was found in relation to cases of 'futility', and increased with age of the therapist. The increasing severity of response was suggested by Elpern et al. (2005) to be related to increased frustration at not being able to change situations despite increasing seniority and experience. However, perhaps it could alternatively show the residual build up of reactive moral distress as similar experiences are repeated. Elpern et al.'s study certainly indicates that prolonged exposure to suffering and the compassion with which it is associated, seems to be associated with increased emotional distress.

#### Resolutions to moral distress

Almost every paper that seeks to study moral distress also discusses potential resolutions to it. Firstly, the nurse can and indeed needs to somehow respond to her moral distress by deciding to perform an action, and as Nathaniel (2006) suggests, many of these actions might be risky to the nurse. As Jameton (1993) pointed out, she may decide on most occasions, as in my narrative, to advocate for her patient and then to comply with instructions and perform the act, or in the words of Nathaniel, to 'give up'.

Alternatively she can refuse to participate in the prescribed medical care, in other words, conscientiously object to complying with medical instruction. She may decide to whistle blow, or to be partially complicit with an instruction whilst sabotaging it. Alternatively she might engage in covert communication as defined by Sundin-Huard & Fahy (1999). Covert communication and sabotage are not topics that are readily found in the research literature for obvious reasons, but

anecdotally it is something that many nurses have on occasions in their careers participated in as has also been observed by Birchley (2011).

As well as individual responses, there are organisational resolutions proposed by authors. For example, Bell & Breslin (2008) and Gutierrez (2005) argue that organisations should provide access to ethics education, ethics debriefings and that ethics committees supported by a clinical ethicist who should be available to health care workers. Erlin (2001), Corley et al. (2005), Kalvermark et al. (2007) describe measures that create an ethical environment, such as open and supportive dialogue. Catlin et al. (2008) argues that chaplains and psychologists should be available and family members be more included in ethical decisions about patients and that ethical dialogue should be encouraged between nursing and medical students.

Education has been identified as a possible route to ease moral distress (Allen, 2003). Lang (2008) discussed the appropriateness of education and Rogers et al. (2008) in a study in palliative care demonstrated that education about issues such as pain management and ethical aspects of care increased nurses' comfort in caring for dying infants. However, although this study described its aims as easing moral distress it should be noted that it addressed end of life care that lacks some of the challenges in acute medicine. Furthermore, moral distress wasn't measured. In contrast, Kalvemark et al. (2007) instituted a series of ethics workshops and ethics rounds for nurses in two hospitals, but found that the moral distress experienced by nurses before and after the input did not change, although they enjoyed the appreciated the events. Austin et al. (2005a) highlighted the importance of integrative educational strategies that identify and

acknowledge moral distress. With regard to the educational approaches suggested by researchers, (Allen, 2003) none suggested that Millette's study of 1994 ought to be considered for structuring learning outcomes. She found that nurses who morally reason with an ethics of care approach as opposed to a justice approach were more likely to experience moral distress. These nurses were found to be more 'morally sensitive', and although neither method of reasoning was seen to be superior to the other, those with an ethics of care approach were far more likely to leave the profession.<sup>7</sup> Nor has any researcher proposed that an assessment of nurse's moral reasoning could be used as a method of identifying and targeting those who are more at risk of moral distress.

Gutierrez (2005) suggests multidisciplinary ethics rounds and that doctors might not be aware of the distress of the nurses with whom they work. Ewing and Carter (2004) describe moral distress specifically as a burden that incorporates a sense of meaninglessness as one of the major factors contributing to moral distress. They instituted workshops that addressed the theological explanations and perspectives on suffering, anger and stress management, and a talk by a senior nurse on the personal caring characteristics of nurses and how this can be the cause of distress, some of which might be moral distress. Although staff valued the workshop and felt supported by one another, no formal evaluation was done to measure long term outcomes, particularly in terms of the frequency and intensity of moral distress.

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<sup>7</sup> It should be noted that reasoning styles are varied in nurses, and in fact many nurses use the justice approach. (Duckett et al., 1992)

In the vast majority of resolutions that are offered to the problem of moral distress, it seems that it is the relationship between the nurse and medical colleagues (or the organisation) that is identified as the focus rather than the initial apparent moral problem, for example, 'futility'. In other words, there is an underlying assumption that it is the secondary harm, rather than the primary harm that ought to be the focus for resolution. This is one of the 'leaps' that I have found in the literature, where the normative stance in the definition of moral distress – that is that an act has been identified as wrong – is contradicted or overlooked by the proposed resolutions. With what essentially results in inclusive and respectful communication, it seems that there is an understanding that moral distress will ease as a symptom. Of course perhaps with increased communication and collaboration between doctors and nurses, patient outcomes might change, but this has not been measured nor is it explicitly referred to.

Finally other resolutions have also been offered, that perhaps could be classified as supporting the spiritual paradigm, such as Tjedje (2000) who suggests that nurses should pay more attention to role models and heroes who have carried out ground breaking work in nursing. She gives the example of Lilian Wald, who contributed to improvement of slums by getting insurance companies to pay for costs of nursing care for slum residents. She argues that such story telling, along with sharing stories of individual situations should be encouraged. Austin et al. (2009) supports Tjedje's position on storytelling, having found that story telling in a paediatric intensive care unit had been found to be helpful. She also argues that accepting and engaging with 'being on the margins', being an 'outsider'

ought to be celebrated by nurses, as they might be more readily able to identify with their patients.

Hamrick and Blackhall (2007) in their review of the resolutions offered by empirical researchers to moral distress point out that although the researchers aim to improve doctor-nurse collaboration, they tend not to offer concrete solutions so often, even though these have been found to be successful in end of life care decision-making. In the field of end of life decision-making such solutions are for example, mandating nurses' involvement in family meetings and holding multidisciplinary case reviews, or adding palliative care teams with a strong nursing component. This seems to me to be an important point that was highlighted at an interdisciplinary meeting on 'Conscience and Moral Distress in End of Life Care (Yale University, 2009). At this meeting, a senior medical consultant in neonatal intensive care was clearly sympathetic to the plight of morally distressed nurses. During discussion he spoke about how his unit had instigated a policy where very young neonates would be given resuscitative care, even though they lived on the boundaries of viability. Only around thirty seven percent of twenty two week old babies survive (Serenius et al., 2007) and of those that do, around half will have moderate to severe disability (Marlow et al., 2005). Catlin et al. (2008) describes how such circumstances clearly fall under those that cause high levels of moral distress for nurses, and assuming that there were ethical arguments that sufficiently justified this action, nurses were not party to them, despite the fact that they would be responsible for carrying out the majority of this care. When the consultant neonatologist was asked who he

had invited to the meeting, he admitted that only medical staff had been invited. He continued that he had not even considered inviting nurses, despite the fact that he readily acknowledged that this would be a good thing. It was clear that this doctor wasn't intending to exclude nurses, he had simply not given thought to inviting them: they were not recognised as professionals who might have a contribution to make, or indeed who might have a right to contribute to the eventual policy, or at least to have that policy fully explained to them.

### Conclusion

So far, I have given a review of the current state of empirical research on moral distress, with some limited analysis of that work, in some areas. It should be noted that most of this work concentrates on critical care environments, and is in the majority, American. Some sources of moral distress are not immediately transferable to the UK, for example issues around provision of finance for medical care by insurance companies, and although in some respects resource allocation and disparity of access to medical care is a ubiquitous problem, some issues such as fairness of access to medical care are not directly comparable across the Atlantic. Furthermore, there are significant differences between nursing professional identity and nursing roles between the UK and US. Some of these differences will be explored in succeeding chapters, but for now, it is important to make clear that although some of the contextual and particular causes of moral distress might differ, the experience of moral distress itself is certainly transferable across national boundaries to an international context. Santry (2009) quoted the Royal College of Nursing's concern that nurses in the UK suffered moral distress in relation to poor staffing levels and moral distress

has been examined by nurse researchers in China (Tang et al., 2007), Japan (Ohnishi et al. 2010), Canada (Pauly et al., 2009), Denmark (van der Dam et al. 2011), Ireland (Deady & McCarthy, 2010) and Sweden (Lutzen et al., 2003) and the fundamental experience can be taken to be common to nurses working in all places. Perhaps most particularly, it is common to nurses during the care of patients at the end of life, this being the area of care that creates the most severe sense of moral distress is experienced. During discussions with my colleagues, students and retired nurses, in agreement with the literature, and as Nathaniel (2006) found in her research, these nurses remembered and recounted their own tales of distress, that they vividly remembered.



## Chapter Two: *The validity of moral distress as a Judgement of wrong-doing.*

### Introduction

Moral distress is primarily an emotional state. In this chapter the nature of moral distress will be more closely examined to see whether or not the concept stands up to challenges to the assumptions that underlie it. Three questions will be addressed. Firstly, given that moral distress is an emotional response to an 'ethical dilemma'; ought it to be trusted? Secondly, ought we to accept the current definition of moral distress? And finally, how will moral distress be defined for this thesis?

### The Validity of Emotions as a source for morality.

As has been described in the last chapter, moral distress is primarily an emotional response to an ethically challenging situation where conflict exists between what a nurse feels ought to be done and her participation in what is actually done. Authors emphasise this emotional response, but only as a consequence rather than as a form of moral judgment. That is, there is an assumption that the emotional response arises due to the inability to do the 'right thing', but that this 'right thing' has presumably been already identified. For example, it could be argued that in the case of 'futile' care, there must be a precondition, based on reason, that futile care is wrong. Perhaps this assumption or reasoned conclusion prior to emotion reflects the *status quo* in ethics where there is a pervasive premise, following a long tradition in philosophy, that a

dichotomy exists between the emotional and rational self, and that ultimately it is the rational self that ought to be relied upon for ethical decisions.<sup>8</sup> Therefore, the nursing literature avoids acknowledgement that moral distress may actually be primarily an emotional judgement (not just consequence) of 'wrong-doing'. Indeed, if moral distress was primarily a rational judgement of wrong-doing, then surely the experiences would be articulated in rational terms, such as a discussion of the conflict between principles and the misidentification of the right principle to be followed in the particular circumstance as commonly occurs in the field of medical ethics (Beauchamp and Childress, 2001) On the contrary, the empirical literature reports experiences that are described in most circumstances, in emotional or sensual terms.<sup>9</sup>

Of course, if moral distress is accepted as an emotional judgment, then it could be argued to be unreliable, because a large body of philosophy supports that rationality is the source for proper identification of right and wrong.<sup>10</sup> In support of this position on the unreliability of emotion, empirical literature has found that different nurses will respond with varying degrees of moral distress. (Jameton 1993; Hanna, 2005; Cavaliere et al., 2010) and if moral distress is accepted to be the same as 'troubled conscience' then Ferral (2006) found that only thirty eight percent of nurses had experienced this, the other sixty two percent presumably felt justified or insensitive to the moral aspects of their actions. This empirical finding has also been reflected in my teaching of qualified

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<sup>8</sup> There is wide spread literature that either argues this to be the case, or that otherwise is clearly based on this assumption. A good introduction to these matters is found in Singer (1991), particularly Part III and IV.

<sup>9</sup> See p31.

<sup>10</sup> See note 8.

and undergraduate nursing students. It has been surprising to find that some students do not express moral distress, even when faced with situations that could be described as clearly and objectively wrong.<sup>11</sup>

On two counts then, it seems that moral distress can be accused of being unreliable as a source for the identification of ethical problems and answers to these problems. After all, emotional responses ought not to be trusted because emotion is unreliable. This is supported by the empirical research cited above, where it has been found that different people respond differently to the same situation. Or more correctly speaking, given that nurses as a professional group share similar professional values, surely they ought to respond more similarly than they do to the same situations. The emotional nature of moral judgement in moral distress could be the cause of this. These challenges to the validity of moral distress need to be addressed.

#### The problem with emotional judgement.

Variability of response in itself is not a reason to discount emotions from ethical analysis: ethical journals exist on the basis that people rationalise and respond differently to ethical questions. However, emotions are often immediate responses to situations and without the inclusion of reason, can lead to less than satisfactory answers to ethical problems; they are unpredictable and can relate more to the personality of the agent and be reliant on the particulars of the

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<sup>11</sup> An illustration of this kind of situation might be for example, a decision to move a gravely ill person to an intensive care unit in order to prevent an increase in audited mortality figures for the ward in question.

situation they are faced with (Crisp, 2008, p242). Such factors can mean that they easily lead to the wrong answers to moral questions. For example, my emotional response to a picture of a desolate dog in need of a home might motivate me to donate money to an animal charity whilst the plight of thousands of victims of a natural disaster that I hear reported on the radio, might motivate me to do nothing, because I was not exposed to an emotive image. In order to make a response that is right for these scenarios, I would need to include reason in addition to my emotion, in order to reach a better judgment, which may be to donate money to both causes. In support of this position, a previous example from the empirical research is relevant.

Laabs's (2005) research on nurse practitioners supports this view. As was discussed in chapter one, nurse practitioners were found to experience moral distress in response to their patients not being able to access care due to limitations in insurance cover (Laabs, 2005). The level of distress in this instance was found to be low in comparison to nurses faced with 'futile' situations. However, the differences that are evident in these responses do not necessarily indicate an accurate assessment of the different levels of wrongdoing. The inequality to access to medical care in the USA is possibly a grave wrong that has been identified as an issue that deserved substantial changes in government law under the Obama administration (*Patient Protection and Affordability Act*, 2010). Despite the lack of moral distress on the part of nurse practitioners, this wrongdoing could be argued to be a greater harm than over treatment of dying patients. In other words it might well be that to die young and poor is a greater harm than to die some days too late. In this case moral distress, at least in and of

itself, does not identify this as such, nor does it identify that this is a disparity worthy of debate.

### The problem with reliance on rationality.

Likewise though, reliance on reason alone can also be problematic. For example, it is difficult to imagine how acts such as killing could be considered unethical without some inclusion of the emotion of empathy in the weighing up of the nature of such an act. A long standing branch of philosophy has sought to identify the place of emotions in responses to ethical challenges.<sup>12</sup> Although one could argue that killing is wrong because it removes the right of a person to life, or because it harms the friends and relatives who are linked with that person, some emotional judgment is brought into the reckoning. For example, a person values their life not only because it is reasonable to do so, but because of the pleasures and events –many of which have an emotional as well as physical and spiritual element – that make up that life. The harm done to friends and relatives isn't only the loss of income or some other utility, but the emotional and relational aspect of that person.

Indeed a lack of emotion, which is at its most basic that primitive and visceral sense of disgust at wrong-doing such as indiscriminate killing, is what is lacking

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<sup>12</sup> A good review of emotions and the various perspectives that range from identifying them as unrestrained forces unequal to rational consideration, to an acceptance of emotion as philosophically valid responses can be found in Van der Cingel (2009) who relates this history to compassion and nursing and a non nursing applied overview is available in the Stanford Encyclopedia of Philosophy (2003)

from people who are psychopaths (Holmes 1991). It seems that it is a lack of emotion, and not a lack of reason in such individuals that can lead to shockingly immoral acts. Such individuals lack the emotionally based constraints to wrongdoing such as empathy for another, or guilt. Sterzer et al. (2007) support this. They found that adolescent boys who had conduct disorder, an aspect of which is to carry out indiscriminate harm to others, have neurological changes in a part of the brain that is associated with empathy. And indeed it isn't just the lack of emotion of empathy that might explain why psychopaths can engage in morally reprehensible behaviour. Herpetz et al. (2001) found that offenders with a diagnosis of psychopathy were found to have a pronounced decreased fear responses and a generalised hypo emotional responsiveness in comparison to the normal population. It should be noted, that my argument does not state that all immorality has as its source psychopathy, but rather, that the lack of empathy and emotionality of psychopaths supports my position that emotion is an important element that contributes to our sense of morality.

Some philosophers have also come to this conclusion. Slote's (2007) thesis on ethics of care, argues that empathy is the core human experience that is essential to the construct of ethics, also supports this position. Authors such as Nussbaum (1986), De Wijze (2004) and Rist (2002) support the position that emotion is an integral part of being an ethical person who makes ethical decisions. Hardcastle (2003) argues in addition to this, that it is an important part of the integrated self and that it is central to a sense of unified agency. Solomon (2003) has written extensively on emotions and their place in ethics, and he provides a model that provides a satisfactory response to rectify the weaknesses of including emotions

in ethical analysis. This approach to emotion as being an appropriate moral judgement so long as it is rationally examined, will be used in this thesis.

### Solomon's Position and a Defence of Emotions as a Component of Morality.

Solomon argues that emotions are judgments of ethical situations. They are an initial response to an 'ethical dilemma' or ethical happening. The object that they judge has to be carefully examined though, with the use of reason. This is because emotions can be easily misunderstood by agents, and without care, it is easy to misidentify the cause of an emotion, or in other words the object that it judges. This misidentification of the object of an emotion and the resultant judgment are at risk of leading to wrong final judgments about action. So for example, in my narrative and in the literature, the distressing emotions that the nurse experiences are generally understood, to arise due to a perception of wrong-doing. Although this might be the case, and my thesis aims to explore this issue in depth, it may also be that some or all of the nurse's emotional reactions are judgments of other causes. So for example, in the narrative, some of the nurse's distress was most likely due to perceived wrong-doing. However, some of her emotional distress was most likely also caused by the dismissive attitude of the registrar. Solomon warns that we may be fully conscious of the causes of our emotional reactions. However, this is not necessarily the case. Again, to use my narrative as an example, some of the nurse's emotional response might have been as a result of associating the treatment due for Mrs Bird with a memory of having cared for another patient in a similar situation, and who she had felt unable to make comfortable.

Meltzer and Huckabay (2004 p205) support this position that other emotional factors can be found to co exist in the morally distressed state. They found that the frequency with which nurses encountered moral distress situations was directly and significantly related to the experience of emotional exhaustion. Sundin Huard and Fahy (1999) further support this, when they found that moral distress was associated with burnout. Closely associated with burnout is compassion fatigue.

Compassion fatigue hasn't been examined in relation to moral distress, but is also a potential correlating factor because it results from being emotionally disturbed by being directly involved with situations where care is given to people under traumatic circumstances; circumstances that are similar to those that cause the most severe form of moral distress (Hooper et al. 2010; Showalter, 2010;). Indeed Joinson (1992) describes effects of compassion fatigue such as turning off feelings, or feeling helpless and angry, which are almost identical to those experienced in moral distress. All of these states mean that the nurse is less able to carry out her work to a high quality.

So, to return to the narrative, it is only in retrospect, with the aid of reason, that the nurse in the narrative can identify that some of her emotions were the guilt and trauma she had experienced at not being able to make the previous patient on doxaparam comfortable, despite all her efforts. Even so, despite an analysis of emotional response, one cannot know for sure, exactly the cause that emotions respond to. They are difficult entities to pin down, and Solomon argues that so



long as they are recognised as such, they can nevertheless alert us to situations that deserve attention. Although they are primitive in nature, this does not mean that they do not deserve this recognition.

This thesis accepts Solomon's position that emotion is a valid form of ethical judgement so long as it is supported by reasoned analysis: indeed this work is one of reasoned analysis of the moral distress that was experienced as an emotional judgement in the narrative. However, once emotion is accepted as valid, it leads to the question of whether or not moral distress is a unique emotional response to a specific kind of circumstance, or whether it is the same as the emotion experienced in all ethically challenging situations.

#### Moral Distress is a Unique Emotional Response to Ethical Challenges.

There are many papers in medical and nursing ethical journals that examine a variety of ethical problems that are not identified as 'moral distress', but that nevertheless could create an emotional response that might be indistinguishable from moral distress.<sup>13</sup>

For example, Hope (2009) discusses the problems nurses face in balancing the care and safety needs of patients with dementia. In prescribing nursing care, nurses are faced with the competing demands of promoting the safety of their patients against promoting their patients' autonomy. These decisions can result

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<sup>13</sup> From now on, for ease of writing I will refer to 'ethical dilemma' even though most situations that are written about in medicine do not constitute a true dilemma; this is a way of describing them in common usage.

in significant changes to a patient's life, resulting in actions designed to reduce that patient's freedom of movement.

Surely it could be argued that reaching decisions around moral dilemmas always result from some kind of constraint, and that that constraint is synonymous with the constraint that is identified as unique to moral distress. If this is so, then moral distress is not such a useful concept. So, to return to my example of safety *versus* autonomy; where a nurse has decided to no longer allow the patient to open the front door due to a worsening medical condition, she nurse will have ultimately conceded that the constraint of keeping the patient safe over rides the constraint of impeding a person's autonomy. Or alternatively, that the principle of acting in the best interests of the patients overrides the patient's right to express autonomy.

Similarly, the doctor who is faced with the dilemma to treat a critically ill patient whose survival is unlikely, has to balance the chance of cure against the prolonging of suffering and the next of kin's wishes. In such a situation the doctor will make his decision again, ultimately on the basis of a constraint, whether that constraint be the non consent of a next of kin, or the limitations of medicine. Most professionals faced with such 'dilemmas' will experience emotional discomfort in making associated ethical decisions. The removal of a person's freedom is an act that most of us would rather not perform, especially if distress on the part of the patient is a 'side effect' of that act. Likewise, treating a patient under questionable clinical circumstances due to the persuasion of next of kin is

uncomfortable if one is concerned about the use of resources and additional suffering that a patient may suffer.

These examples not only highlight that all 'ethical dilemmas' involve having to face some kind of constraint, but that in most circumstances there is also an associated emotional discomfort. What requires clarification here, is whether or not 'moral distress' deserves attention as a unique kind of emotional distress, and if so why. In order to achieve this each of the previous examples will be reviewed.

If we return to the case of the nurse who decides to remove a patient's freedom for the sake of safety, although she might experience some emotional discomfort, and indeed, this emotional discomfort could continue after the decision, when she is faced with the consequences of that decision, such as the patient becoming disorientated or angry at not being able to open a door, that emotional distress is countered by a sense of having reached the right decision. In other words, the constraint that the nurse applied to the original situation, was one that she agreed to be right. It is a risk at this point to over simplify this sense of rightness. Although it is true that the nurse could have concluded that the constraint of safety ought to override the constraint of promotion of autonomy, it is possible that she also came to the same conclusion for different reasons. For example, she might have come to the decision to promote safety because she agrees it to be right that hospital health and safety policy be followed, over and above any consideration of patient autonomy.

Likewise the doctor who decides to treat a patient based on the wishes of the patient's next of kin, may well suffer discomfort at seeing the consequences of his actions – the prolonged suffering of the patient or use of resources – however, that discomfort is countered again, by his belief that he has made the right decision. In this instance, under unhelpful but also uncertain prognosis, he may well agree that next of kin wishes to treat ought to take precedence over his own clinical judgment to end treatment. However, as in the previous example, the doctor might make this decision based on other criteria, such as believing that it is right to follow hospital policy if that policy states that involvement of next of kin in medical decisions is to be promoted. Indeed, as has been found in the empirical work, not all nurses experience moral distress and presumably it is because they have come to a conclusion as is exemplified in the examples above, where some reasoned justification has been made whereby no conflict is experienced.<sup>14</sup>

At this point then, it has been demonstrated that emotional distress is associated with reaching decisions in many 'ethical dilemmas'. However, this distress is not the same as 'moral distress' because the nurse or doctor has come to some kind of resolution, whereby their decision is in congruence with what they identify to be right. They have faced a constraint, as is the case in 'moral distress', but that constraint is one with which they do not disagree. Following on from this then, it ought to be asked does any situation where a constraint is faced and conceded to, but that where that constraint is not agreed with, result in moral distress? Certainly the literature and the two common definitions of moral distress that

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<sup>14</sup> See p41.

were given at the beginning of this chapter would seem to indicate this. So, the nurse who decides to lock the door for a patient for the sake of hospital policy, when she believes the hospital policy to be wrong, will suffer what is called 'moral distress'. Likewise, the doctor who follows the next of kin's wishes, but believes that it is wrong to allow next of kin to influence clinical decisions, will suffer moral distress if she concedes to the constraint of following the next of kin's wishes that she believes to be wrong.

Some of the research literature supports this stance. For example, the psychiatrists who were found to experience moral distress caused by their compliance with the legal system, suffered moral distress precisely because they conceded to a constraint that they did not necessarily believe to be right (Austin et al., 2007). Similarly, the moral distress caused to nurses working at staffing levels they believe to be set too low by hospital management, are also working under a constraint that they believe to be wrong (Rodney & Starkomski, 2005).

In these examples, and as the previous discussion of the varying natures of constraint have illustrated, certainly we can narrow emotional distress in ethical decision-making, to 'moral distress' on this basis. Furthermore, moral distress can be distinguished from other forms of emotional distress, firstly because it involves having to accept a constraint. Secondly though, it can be distinguished from other forms of emotional distress because by necessity, the professional must identify harm in her interpretations of the situation. This takes the nurse who experiences moral distress beyond the nurse who is equally or perhaps more distressed in the face of great suffering. Suffering and the distress it causes

is part of the natural order, and therefore does not include malicious intent, wrong professional judgement or preventable harm that is identified in moral distress.

However, I'm not convinced that the definition of moral distress so far given is sufficiently narrow for fruitful ethical analysis. It results in a situation where all professional groups and all health care professionals (HCPs) are described as experiencing something similar, when perhaps it ought to be a concept that is narrowed to use for nurses only, and aside from nurses, only for groups of professionals who share many characteristics with nurses.<sup>15</sup> In order to support this position, the difference between moral distress in these instances (ie other professional groups) and moral distress where it is experienced in its more extreme forms, has to be considered.

#### Moral distress is too broadly defined

As was described in the first part of this chapter, moral distress is suffered in its most extreme form, or in other words at its most distressing, when nurses are faced with caring for patients who are perceived to be in 'futile' situations, and where aggressive medical care is continued. As in the previous examples of the nurse and doctor who face the patient with dementia and the critically ill patient, or the psychiatrist and the nurse working under an unwelcome law or low

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<sup>15</sup> McCarthy & Deady (2008) also discuss the problems with definitional accuracy in moral distress but argue instead for a broader concept which includes all health professionals.

staffing levels respectively, the nurse in the 'futile' situation also concedes to a constraint that she does not agree with.

However, the nurse in the 'futile' situation experiences conditions that are distinct from the others. First of all, she is directly exposed to the suffering of life and death consequences. Furthermore, unlike the doctor who faced the same kind of situation, she will remain with the patient and experience far more exposure to the negative and distressing consequences of a decision to treat. Indeed as Slote (2007) points out, to act has associated with it a higher causal responsibility than not to act; in other words sometimes to omit to act can be psychologically easier than to act. Nurses do not describe these experiences explicitly, but instead describe suffering they feel they cause and observe in metaphoric terms such as 'torture' (Hefferman & Heilig, 1999, Gill, 2005), 'flogging a dead horse' (Heland 2006) or 'keeping dead people alive' (Erin et al., 2005, p524)

Again, unlike the doctor, she will be the person who will carry out much (although not all) of this 'flogging', and if she doesn't directly 'flog' herself, she will assist in that action. The nurse is proximal to the patient and this proximity is associated with increased sense of moral distress (Torguul & Sorlie, 2006) and as Slote (2007) argues, 'perceptual and temporal immediacy' is associated with greater empathy with another's plight and suffering. (p27)

Along with these differences, ultimately the line that distinguishes the nurse from the doctor, is that the authority to decide lies with the doctor, and the

doctor has the authority to instruct the nurse to carry out the medical procedures. The constraint that the nurse experiences in this situation is not only a matter of weighing up moral principles and constraints, but is rather, a matter of what and who she is defined to be. Her situation could be argued to be similar to that of the junior doctor who carries out the instruction of his senior.<sup>16</sup> However, the junior doctor, unlike the nurse is not so exposed to the consequences of medical decisions because he does not remain with the patient and is not responsible for assessing and resolving those consequences. In addition to this, the junior doctor is in a training position, where eventually he will become the person who has authority to make those decisions. Although he might be currently constrained by who and what he is, unlike the nurse, in the foreseeable future the doctor will no longer be.

It could be argued that doctors are also constrained by authority in so much as they are also limited by hospital policy, resource allocation and political decision-making. However, although this may be the case, even so their position is different to nurses. Although the consultant psychiatrist might disagree with the law's position on preservation of the safety of society, he is in disagreement with a body of professionals who are recognised as his equal in terms of social and intellectual status. His voice will be heard in media discussion and the committees that reach consensus about such decisions. The nurse is not recognised to be of equal status, socially or intellectually. Who and what she is recognised to be, is a constraint that is not shared by the doctor. The events of

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<sup>16</sup> Moral distress has been identified in junior doctors (Hilliard et al, 2007) and questions of how to manage it have been raised in medical literature recently (McDougall, 2011).



the Yale (2009) meeting on conscientious objection further supports this distinction.<sup>17</sup>

In conclusion to this argument then, it seems that moral distress can be defined as the emotional anguish that results from carrying out the 'wrong' action (perceived or actual) in response to constraints that stop one from carrying out what the nurse identifies to be the 'right' action, as is proposed by Jameton (1984 and 1993), Nathaniel (2006) and Wilkinson (1987). Further to this, I propose that moral distress is primarily an emotional judgement of 'wrong' action that requires further rational analysis.<sup>18</sup> However, this definition leads to a situation where many morally charged situations can lead to moral distress, and be experienced by a wide variety of professionals. The broadness of this definition means that it is difficult to grasp a set of moral issues that are directly and uniquely associated with the concept. Moral distress is capable of jumping from staffing levels (Rodney & Starkowski, 2005) to end of life decision-making, (Ferral, 2006, Elpern et al., 2005; Hamrick & Blackhall, 2007) from legal issues around the safeguarding of society (Austin et al., 2007) to the ordering of a disgruntled queue of patients who await dispensation of drugs from a pharmacist (Kalvermark et al., 2006). This broad variety of causes, in the end leads one to question why moral distress ought to be considered as a concept at all? Why not simply look at each of these morally charged and objectively

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<sup>17</sup> See p37.

<sup>18</sup> This is not to say that moral distress is without rational judgement, but rather, that it requires further rational input to avoid the normative recommendations that are currently offered without further rational examination.

different situations and weigh up the rightness and wrongness associated with each separately?

In answer to this challenge, it seems that moral distress becomes important when the issues associated with it can be collectively shown to be in association with not only moral distress, but when the issues can also be shown to be in association with one another, and finally and most importantly, when these issues impact on patient care.

The evidence indicates that moral distress leads to nurses leaving the profession or leaving specialist areas of practice or withdrawing from patients in such a way that care is replaced by concentration on technical aspects of care. In other words it often leads to nurses nursing less well.<sup>19</sup>

Although there is comparatively little work done on doctors and moral distress, that work that has been done as has been previously stated, shows that doctors do not seem to leave or change their specialisms in response to moral distress, they do not report that they omit to carry out some of the responsibilities of their role as does the nurse. In addition to this, the nature of their work seems to lead to a different kind of stress that can sometimes be rewarding<sup>20</sup>

In order to make moral distress a concept with greater validity it ought to be more narrowly defined. That is firstly, that moral distress arises when a

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<sup>19</sup> See p31.

<sup>20</sup> See p30.

professional is requested to perform an act that they perceive to be wrong. Secondly, that it is an act that they concede to carry out because the authority to decide that the act is to be performed, lies with some one else. In its strictest sense, and this I wish to promote in this thesis, this authority ought to be someone who lies outside of one's own professional group. This means that nurses can be shown to experience moral distress, but the junior doctor does not. Put simply, moral distress arises when a person doesn't want to do something, but has to do it because someone else, and who is different to them, has told them to. This sense of moral distress certainly pervades the literature.

As has been discussed, the contextual constraint that is repeatedly referred to, is often described as a power imbalance. Interestingly, the more narrow definition that I have come to is perhaps a more correct version of what most of the literature seeks to describe and resolve. However, maybe there is a resistance on the part of nurse researchers to fully accept that this 'power imbalance', exposes the fact that moral distress is a consequence of who the nurse is and what she does. In other words, moral distress arises in a professional who is under the authority of another profession and who is duty bound by the very definition of who she is, to do what she is told to do. This differs from the literature because the literature insinuates this power difference as a wrong rather than statement of fact.

If indeed a power imbalance exists, it is one that is embedded in the role that the nurse inhabits and contradicts the concept of nurse autonomy that is so

frequently referred to in academic literature and job descriptions.<sup>21</sup> Finally, the definition should include proximity to suffering and the perception of harm being done to another. In other words, it ought to be acknowledged primarily as an empathic response to another that ends in anguish for the professional because they perceive that what they are doing is harmful. For this thesis then moral distress will be accepted under the resultant definition that:

‘moral distress is a nurse’s emotional judgement of primary wrong-doing to the patient and secondary wrong-doing to the nurse and indirectly the patient, that is based on close proximity to and empathy with, a patient’s suffering and the perception that she increases that patient’s suffering through performing actions for which she is responsible, but that are under the order and authority of another professional group; usually the doctor.’

This definition is the basic premise that supports the choice to accept moral distress in nurses as a valid term.

### Conclusion.

The validity of moral distress as an emotional judgement has been defended and a narrow definition that identifies moral distress as being unique to the nurse who is proximate to her patient’s suffering has been formulated. Emotional

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<sup>21</sup> Nurse autonomy will be discussed later. Job descriptions in the nursing press often refer to clinical nurse specialists as ‘autonomous practitioners and / or state that the nurse needs to be able to act autonomously in the job descriptions.

judgement of 'ethical dilemmas' has been accepted to be an important element of morality. Solomon's view that this element of morality is valid so long as it co-exists with reasoned analysis has been accepted as the foundation from which the rest of this thesis will develop.

Chapter Three: *Conscientious objection to futile orders: An analysis of Catlin et al. (2008)*

Introduction

Although a number of other potential actions in response to moral distress have been described; choices such as covert communication, subversion and whistle blowing, in this thesis, consideration will be narrowed to the question of, to do or not to do as was expressed in the narrative.

Having narrowed the definition of moral distress in chapter two, from now on, moral distress as a result of ‘futile’ doctors’ orders will be examined. This was the question that was raised in the original narrative where the nurse identified ‘futile’ orders, where she advocated for the patient and argued for the discontinuation of those orders, and where she finally faced the decision of whether or not to carry out those orders.

This chapter will begin with a justification for use of Catlin et al.’s (2008)<sup>22</sup> paper as a foundational piece for reasoned analysis of moral distress. After this, the remainder of this chapter will be a review and initial analysis of her proposals that will be further examined over the coming chapters. It will include both a report of Catlin’s ideas, but also some preliminary discussion about inferences about the assumptions and arguments that she promotes but that are not explicitly stated. The analysis will be limited to deciphering Catlin’s meaning,

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<sup>22</sup> For ease of reference I will refer to just ‘Catlin’ from now on.

along with some comment on internal validity and where appropriate, a clarification of some omissions and confusions that have been identified. Where papers are referred to that support or do not support her position, these have been found on external review of the literature. Papers that she cites will be indicated as such.

### Moral distress and its relationship to conscience.

Catlin proposes that the ANA code of nursing (ANA, 2001) ought to be altered so that conscientious objection is supported as a response from nurses who are morally distressed by 'futile' orders, or in the words of Catlin, to instigate protocols that would refuse 'to provide end of life interventions that cause suffering, appear to be harmful, or seem futile.' (p.106)

This paper has been chosen for a number of reasons. Firstly, there are many papers that address similar circumstances and experiences to moral distress and that define the experience as 'troubled conscience'. (Juthberg & Sundin, 2010; Dahlqvist et al., 2009; Gronlund et al., 2011) or 'stress of conscience' (Glasberg et al., 2007; Juthberg et al., 2010). Indeed, they are divided from papers on moral distress only as a matter of definitional terms that lead to a slightly different emphasis in terms of how analysis is made, but essentially moral distress is synonymous with a crisis of conscience, except that in moral distress constraints are identified as primary and secondary causes that lead to harm.

Secondly, the question that the nurse in the narrative felt impelled to answer was one of how to act in good conscience. She identified a situation where she could refuse to carry out a doctor's orders; Catlin proposes a change in the nursing code of conduct that could make such an act one that is professionally sanctioned.

Thirdly, like the nurse in the narrative, Catlin is not alone in framing conscientious objection as a justifiable response for nurses to make in relation to doctors' orders. For example, Katz Sperlich et al. (1996) describe how nurses collectively took a conscientious stand against male circumcision that is performed routinely in the US in babies, and that led them to collectively conscientiously object to assisting doctors in carrying out the procedure. Subsequently hospital policy was restructured to specify how objecting nurses were to be accommodated and no longer have any obligation to participate directly in the procedure (St Vincent's Hospital, 1995)<sup>23</sup> This case does not specify moral distress as a factor in the decision-making process, and indeed the definition I have made of moral distress does not necessarily include male circumcision as a possible cause, although it does seem reasonable to propose that at least some nurses involved in the procedure might be included in my own definition.

There is also anecdotal evidence that nurses might wish to claim the right to conscientious objection to doctors' orders. Allnurses.com (2002) hosts a

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<sup>23</sup> There is a youtube video of some of the nurses' responses 'The nurses of St Vincent's saying 'No' to circumcision' (2006)



discussion between nurses that was begun by a nurse who refused to administer pain relief as prescribed by the doctor. Conscientious objection featured in the subsequent discussion.

In addition to this, in a broader context, Catlin does not stand alone in making the suggestion that conscientious objection in the face of higher authority in medical decision-making might be an ethically justifiable response to distressing circumstances. Birchley (2011) also proposes that conscientious objection to more general and non-specified situations ought to be promoted as a recognised right for HCPs. Although my analysis will concentrate on Catlin's work, it is worth noting that Birchley argues for the rights for health care workers to conscientiously object. However this differs from Catlin. He argues that all HCPs ought to be able to conscientiously object but that this objection would be required to be presented to a committee of professionals and lay people. The purpose that this would fulfill would be to safeguard patients and to prevent surreptitious activities in health care practice such as those found in the Tuskegee experiment (Jones 1981) This contrasts with Catlin's position, who presents conscientious objection as an individual or group action, but nevertheless demonstrates a broader interest in conscientious objection that extends beyond the typical cases such as abortion.

The scholars at the meeting on moral distress at the Bioethics Center, Yale University (Yale University, 2009) also met to propose a project to write a book on conscientious objection as a resolution for moral distress. Although taking a wider remit than the conscientious objection to aggressive medical treatment as

suggested by Catlin, this, along with the other papers identified, demonstrates that there is a consensus that conscientious objection might be justified.

Fourthly, Catlin directly relates the empirical description of moral distress to the philosophical concept of conscience and gives a solid justification for the normative recommendations to incorporate conscientious objection in the American Code of Ethics for Nurses as a response to moral distress. Such a recommendation allows for further exploration of the nature of wrong-doing that much of the literature in the field insinuates but does not meet 'head on'. As has been stated, most of the discussion about resolutions to moral distress focuses on activities such as improved communication and education.<sup>24</sup> This bypasses the earlier explanations of the causes of moral distress that such authors identify, and that were termed 'primary harm' in chapter one.<sup>25</sup> Catlin's solution however, allows for the possibility that harm may in fact be being done to patients, thus justifying conscientious objection.

To narrow the analysis of moral distress to that of conscience and conscientious objection, means that the nature of primary harm that moral distress may or may not indicate can be grappled with. Is overly aggressive medical care a wrong-doing that nurses ought to disassociate from? Further to this, conscientious objection is an action that firmly asserts the autonomy of an individual to have control over his or her own actions. It concedes that a person is responsible for his or her own actions, and in so doing it also faces the secondary harm of the

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<sup>24</sup> See p33-38

<sup>25</sup> See p22.

power difference between doctors and nurses, that authors have identified. Conscientious objection makes clear that ultimately, whatever the power relations, no person has authority to make another do something that they believe to be wrong.

Of course there is also a vast array of literature around the subject of conscientious objection and abortion and emergency contraception.<sup>26</sup> This literature is not of specific interest to my research question *per se* because it addresses a well-trodden path that examines the rightness of killing *in utero*. However, some such literature will be used to inform the arguments that will be presented and that ultimately will come to the conclusion that nurses ought not to conscientiously object to doctors' orders in the case of moral distress as I have defined it for my thesis.

Finally, depending on the answers to the questions of the accuracy of moral distress being described as a matter of conscience and thereafter an accurate identification of wrong-doing or not, it will be possible to explore resolutions to moral distress that do not leap from empirical descriptions to normative resolutions as is the case in the current literature.

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<sup>26</sup> Hanna (2005) did carry out a research study on moral distress and nurses who assisted in elective abortions. The association of moral distress with nurses who conscientiously agree to participate in abortion means that this study might be flawed in so far as its definition of moral distress might be contended. Nevertheless the results are interesting and emotional responses of the nurses are congruent with those experienced in moral distress in its more broadly researched form.

However, there are some potential problems with Catlin's paper that require defence. The focus of this thesis is the UK, and Catlin's is a US paper. There are some differences in the ideologies exposed in the Code of Conduct for the UK (NMC, 2008a) in comparison to the Code of Conduct in the US. Furthermore, there are differences in health care delivery that could make an extrapolation of the proposals that Catlin makes to the UK, invalid. However, these differences are not great enough to undermine the basis for such an extrapolation.

Firstly, although Catlin's paper is US based, the development of nursing within the UK has been significantly influenced by seminal theoretical work in the US and dialogue exists across continents in international journals that examine nursing practice.<sup>27</sup> The similarities between the continents and between the bedside practice of nursing and medicine are more similar than dissimilar. In addition to this, much of what nurses do in the UK, including the development of specialist roles and degree level educated basic level nurses, has been inspired by the work of the profession in the US and therefore my examination of the ideas in the US are important because they could be seminal in changing ideas and working practices in the UK and the rest of the world (Woods, 1997; Davis, 1999). This historical development of nursing will become significant later, when I will argue that it has led to invalid assumptions about the nature of nursing that contribute to the sense of moral distress that nurses experience.

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<sup>27</sup> There are many contributors to this work, but Benner (1984), and her work on the development of nursing expertise and Henderson (1997) and Orem's (McLaughlin Renpenning & Taylor, 2003) development of an understanding of the nature of nursing care and Parahoo's (1997) early consideration of nursing research have all had influence on the development of the nursing process, nursing models and the development of nursing research in the UK.

Finally, although there are distinctions between US and UK healthcare delivery that create unique ethical questions that relate to each - for example the inequalities and conflicts of interest that arise in the privately funded US health care system creates empirical scenarios and ethical concerns that are not reflected in the centralised finance system that is present in the UK (Stone, 1993; Baker et al., 2001; Baker et al., 2011), the experience of moral distress is a ubiquitous problem for nurses internationally, where the constraints to practice are shared by nurses whatever their nationality. This is supported by the research performed on moral distress in the variety of countries identified in chapter one.

Second to the fact that this paper is US based, it is also written with specific reference to neonates in intensive care and children in paediatric intensive care. Some of the ethical issues that arise in such clinical work are specific to the age of the patients. For example, viability and active treatment at the limits of viability will be particular circumstances that cause moral distress in the neonatal nurse and not the adult nurse.<sup>28</sup> However, all branches of nurses suffer moral distress in common, and adult and childrens' nurses have also been shown to suffer moral distress in many care settings where 'futile' treatment is considered to occur. The neonatal nurses and nurses in other fields will suffer moral distress under the definition I offered in chapter two. Catlin's description of moral distress clearly falls under this definition.

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<sup>28</sup> This has already been discussed in previous chapters, but Janvier & Barrington (2005) provide further discussion about the clinical outcomes associated with active treatment of neonates at the limits of viability.

As shall soon be described, Catlin's arguments about the appropriateness of conscientious objection as a response to moral distress is applicable to all nurses who are exposed to aggressive treatment of patients; patients who morally distressed nurses would rather see treated palliatively.

She presents a paper where the empirical work done to find out about nurses' attitudes towards and use of conscientious objection in cases of moral distress, leads on to a normative recommendation that the nursing code of conduct ought to be changed to support conscientious objection when nurses are faced with situations that they believe allow the delivery of aggressive medical treatment to deny a patient's rights to palliative care. Should such a proviso have been included in the NMC code of conduct, in my own narrative, the nurse would certainly have conscientiously objected to setting up the doxapram infusion and conceded to the offer of another colleague set up the infusion for her.

#### Catlin: Underlying assumptions, empirical findings and arguments.

Catlin begins her paper by establishing what I will term her 'foundational assumptions' about the nature of nursing and moral distress. She argues that nurses are a body of professionals with a long theoretical history in which the nurse is defined as a person who is called to care by patients and families and communities and who responds to the person under her care in a way that is beneficial to the recipient and meaningful to both the recipient and herself.

She uses four authors to offer her definitional understanding of moral distress. Firstly she quotes Jameton's (1984) definition of moral distress as a phenomenon that occurs when the nurse knows the right thing to do but can't do it because constraints stop her from doing so. She then quotes Rushton (2006), who states that moral distress occurs when clinicians are unable to put moral choices into moral action. Thirdly she quotes Gordon and Hamric's (2007) assertion in their paper on nursing advocacy, that nurses have a moral imperative to do the right thing. Finally, she quotes Rushton and his assertion that where a nurse is unable to take the right course of action she is obliged to maintain her personal and professional integrity and raise a conscientious voice and possibly to make a conscientious refusal. This choice of authors indicates that Catlin takes the view that nurses have access to knowledge about the 'right thing' to do when others – that is the organisation, doctors or families – seem to prefer to do the 'wrong thing' or fail to see that what they do is wrong.

It is important to have a clear understanding of what Catlin understands to be the 'wrong thing', and in this paper it is explicitly described as the overuse of technology that causes suffering and effectively denies those who will die, access to proper care, that ought not to be curative in nature, but rather, palliative. She uses Kain (2006), Carter and Leuthner (2003) and Levetown (1996) to support her position. These authors do point out the burdens of treatment, for example in the case of Carter and Leuthner, the controversy over artificial hydration and nutrition in neonates is examined and the burdens of such treatment in the dying compared to some advantages of the alternative state of starvation, put forward amongst the reasons to withdraw such treatment as a palliative measure.

Catlin's position is supported by other authors who she does not cite, such as Solomon et al. (1993) who found that many nurses and house officers had acted against their conscience in end of life care, where they felt that overly burdensome treatment was given to patients and the perception of artificial hydration and nutrition remains an issue that makes nurses and doctors uncomfortable (Schmidlin 2008; Van der Riet et al., 2010). Such concerns are also relevant to nursing of adult patients who for example, may seem to have a prolonged death after medical treatments such as artificial feeding (Krishna, 2011). Indeed some authors go so far as to question the morality of hand feeding patients who are likely to become intensive care dependent thereafter (Cochrane 2009).

However, the evidence in this field is not conclusive, empirically nor ethically. For example, in a retrospective study on patients who received palliative care on an oncology ward, Krishna et al. (2010) found that artificial hydration did not alter hydration related symptoms or medication use, nor did it extend the survival of patients. Undoubtedly some practitioners would have wrongly perceived this intervention as the unnecessary extending of life. However, this study showed that although it didn't seem to improve matters, it did not make them worse either. Higginson et al. (2003) in their systematic review of the literature on the benefits of palliative care teams, further muddy the waters, and found that these teams did not bring significant benefits to patients in the hospital setting. Timmers et al. (2011) found that nurses in a general adult intensive care unit could expect mortality rates to be around sixteen percent in the ICU, and the ward nurses who followed through care for patients admitted



from ICU, could expect to see eleven percent of the patients who come from ICU to die before discharge. Clearly, whatever treatments are used, nurses are in the difficult position of caring for a significant proportion of such patients who will die. Of course, the alternate view is that the majority survive such treatment. Furthermore, the expectation that the experience of death can be improved or shortened is not an end that can be predicted or achieved with certainty. Ironically, it is likely that good nursing care also extends dying, as patients are prevented from developing pressure ulcers, are moved to promote circulation and breathing and so on.

It is important to take note that Catlin's position that nurses ought to be able to conscientiously object to care orders that deny a patient palliative care, does not refer to the doctor who refuses to give a patient who is acknowledged as dying, palliative care; but rather, refers to the doctor who continues to treat a patient who the nurse identifies ought to be allowed to die instead.

She does not make this distinction in meaning clear and this is an error in her work – both of these circumstances are morally different. If a doctor were to deny a patient who is acknowledged as dying, palliative care, then this would clearly contradict what is acknowledged to be good practice and be morally wrong. However, in the case of the patient who is treated until the very end, even though it would have been better to offer the same patient palliative care, it is not until the event of death that one can be certain that palliative care would have been the right option. Until retrospective judgement can be made then, here the doctor it could be argued is in a morally grey zone that is defined by

uncertainty of outcome or as Repenshek (2009) identifies it, moral distress under such circumstances is a discomfort at being in a state of moral subjectivity. The right way forward is neither clear nor necessarily agreed upon.

The two potential circumstances – that of denying a patient who is acknowledged to be dying palliative care and that of denying a patient palliative care who is not generally acknowledged as dying - might give rise to what is termed ‘moral distress’, if the nurse is constrained from doing the right thing. But as has been noted, Catlin does not seem to be talking about the former. As I will discuss in later chapters, the first situation ought to be termed ‘moral outrage’ as it is not in a grey area, but is clearly a wrong-doing, if professional and institutional standards are taken as the norm. Moral outrage has been defined as anger provoked by the perception that a moral standard has been violated. (Batson et al., 2007) Similarly to moral distress, the emotional nature of moral outrage, leads to problems with its interpretation too (O’Mara et al., 2011).

To support her position, that presumably refers to the latter meaning, that is ‘futile’ care orders, Catlin quotes the American Nurses Association’s (ANA, 1993) report that careful assessment of the appropriateness of providing high- tech curative medical care to those who require comfort, relief and a peaceful death should be made to avoid futile treatment (p 102) She also quotes Paris & Shreiber (1996) who state that ‘futile care’, at the request of patients themselves or relatives, who are not ready to see a loved one die, ought never to be delivered to patients, because patient autonomy becomes irrelevant under such circumstances, even if relatives wish treatment to continue. The ‘wrong thing’ is

therefore happening in health care and requires to be rectified because Paris & Shreiber observe that patients and relatives can have undue influence on medical staff. Of course again, this has to be balanced against the evidence that doctors will stand against the views of relatives, when futility is certain. However even in the case of extreme prematurity legal cases have shown the complexity and conflicts of opinions between doctors and relatives, and where the law will support treatment where basic aspects of quality of life even in those severely disabled, can be shown to be of value to parents (Morris, 2009).

Implicit in Catlin's work are two arguments that I have identified during my analysis. The first relates to moral distress and the primary and secondary nature of harm or wrong-doing, and the second relates to the nature of nursing. I will deal with each in turn.

### The Nature of Wrong-doing.

Firstly, Catlin does not just identify 'wrong-doing' as the hopeless case where futile treatment is given in the situation of what seems to be impending death. She also insinuates another 'wrong thing'; that is to treat patients where life can be extended 'beyond cognition or function' (p102). This statement is not developed any further in her paper, but clearly indicates a different understanding of wrong-doing, that has a different meaning to prolonging a death. This statement does not draw on the ethics of dying, but rather the ethics of quality of life and the various interpretations that can be made about a life worth living in disabled circumstances. As was drawn attention to in chapter

one, in the case of some neonates, high tech treatments will result in the saving of lives that will be severely disabled (Marlow et al., 2005). The nurse then, can be morally distressed not only because a patient is denied the right to a peaceful death but also because medical treatment can enable or force, depending on one's perspective, the patient to continue to live. In the adult field nurses can be morally distressed by the placement of gastrointestinal feeding in elderly patients post stroke. Denti et al.'s (2011) study supports their concern about the outcome for such patients in terms of disability and prolonging of death. Denti et al. found that outcomes tended to be very poor for very elderly stroke victims.

Second to this, Catlin, also insinuates that the nurse has a unique perspective that seems to have the ability to identify wrong-doing when others, such as the doctor or relatives, do not. Although I have cited papers that clearly demonstrate that the field of aggressive medical care is full of ethical and empirical complexity, Catlin and other authors who write on the subject of moral distress simplify the debate to one where aggressive treatment becomes 'futile' treatment. This perspective in the eyes of Catlin, leads to the obligation for the nurse to act as the patient's advocate. This twofold aspect of nursing – the unique perspective and the nurse as advocate – is key to our understanding of and response to moral distress, but is most often not directly and explicitly referred to. Again, this will have further attention in later chapters.

## Conscience and conscientious objection

Catlin links moral distress with the ANA's (2001) code of conduct statement on conscientious objection. This will be explored further in chapter six, but for now, the ANA states that nurses have a duty to preserve both their sense of personal and professional integrity and to participate in 'integrity preserving compromise only to the degree that it remains an integrity preserving compromise' (5.4) Nurses who are in situations that –

'exceed acceptable moral limits or involve violations of the moral standards of the profession...may express their conscientious objection to participation. Where a particular treatment, intervention or activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardise both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Conscientious objection may not insulate the nurse from formal and informal penalty.' (5.4)

With reference to this idea, Catlin brings up the right of the nurse to act non malificently and makes reference to the unique perspective of the nurse in relation to her 'right and responsibility' to act as patient's advocate (p103). She doesn't explain exactly why moral distress equates to a troubled conscience – indeed she doesn't mention the words 'troubled conscience'. She does define

conscience as the awareness of the moral quality of an action (Encyclopedia of Bioethics, cited on p 104) and that:

‘Using one’s conscience implies a moral sense, internalized norms, and a sense of integrity. A crisis of conscience is an attempt to restructure one’s deepest and most fundamental convictions.’

It seems therefore that she equates moral distress with a ‘crisis of conscience’ and that the crisis the nurse faces in moral distress presumably must involve an assault on her convictions. In response to this crisis of conscience, Catlin argues that the ANA position on conscientious objection ought to be redefined to specifically include objection when a patient is ‘denied palliative care’, (p103) and when the nurse suffers a high degree of moral distress. She doesn’t explain why this addition ought to be necessary, as surely a patient being denied palliative care is something that would be morally objectionable to nurses as stipulated in the ANA statement already. Based on my analysis of Catlin so far, perhaps she believes that this situation ought to be explicitly described because, based on her findings with regard to ‘futile’ treatment, the overtreatment of patients is a wrong-doing that the nurse has a specific obligation to prevent. Further to this, implied in the need for conscientious objection is the fact that the nurse is powerless to effect a change of treatment for such patients.

### Conscientious objection as a collective activity

On analysis it became clear Catlin's and the ANA's understanding of conscience and conscientious objection moves beyond the understanding of conscience as the concern of the individual who exists in a wider community. This move away from the individual is a step beyond the focus of conscience as it is ordinarily understood and I will return to this in later chapters. However, at this point it is important to note that both the ANA and Catlin seem to include nursing or the nursing profession as a whole and not just the individual nurse and her individual values as a focus for conscientious objection; or perhaps the other way to understand this, is that the act of conscientious objection protects both the integrity of the single nurse and the nursing profession. This is observed in the ANA's stipulation about the moral status of the profession and nursing practice – both of which are a professional rather than personal value. This is clear when Catlin proposes that where one nurse conscientiously objects, others might agree with the stand and subsequently a change in practice might occur (p104). During her paper, Catlin has a tendency to shift from the individual nurse and her own values and the nursing profession and its values. Mostly she addresses the individual nurse, but this group aspect of conscientious objection is certainly present, and although she doesn't explicitly state it, it is reasonable to assume that one way of influencing change where a number agree, is by a number of nurses conscientiously objecting at the same time.(p104) As was previously stated, this action was what changed policies on nurse participation in non therapeutic male circumcision in St Vincent's Hospital in the US.

Later it will be argued that conscientious objection on the part of the individual nurse and on the part of the profession are two different things. Catlin does not specify what this 'change in practice' might be, but presumably it might lead to an alteration in the course of treatment of a specific individual, or else it might lead to a change in policy and practice towards many individuals. In other words, if enough nurses conscientiously object to the 'denial of palliative care' to individuals, then the 'denial of palliative care' may cease as a wrong-doing.<sup>29</sup> Of course such an end would have ethical consequences. Some patients who would have survived against the odds would instead die. The over simplistic view of wrong-doing that can be presented in cases of aggressive treatment that does not save a life, again fails to recognise the moral uncertainty in such situations as Repenshek (2009) highlighted.

#### Conscientious objection – Catlin's view of supporting literature

This shift to a more collective understanding of conscience described in the last section is perhaps linked to Catlin's concentration on the military and conscientious objection. In her search for papers on conscientious objection and nursing she mentions only the six articles that she found through a CINAHL search. She reports that five of these are about abortion and that only one refers to the rights and barriers to objection (p104). This mention of the words 'rights and barriers' seems to infer a lack of power on the part of the nurse.

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<sup>29</sup> It should be noted that the conscientious objection to male circumcision that was made by nurses at St Vincent's Hospital didn't stop the practice, only the obligation of nurses to be involved in it.



Further to this proposal, it is interesting to note that she does not mention or analyse the many sources that are available on conscientious objection that relate to health care law and conscientious objection in medicine.<sup>30</sup> Instead she bypasses these papers, that often discuss the detrimental effects of conscientious objection on patients such as denial or difficulty in obtaining access to legal medical care and moves instead to discuss conscientious objection in the military.<sup>31</sup>

#### Catlin's Comparison between Military and Nursing Conscientious Objection.

She states that nurses are similar to soldiers who object to individual wars or specific acts of war when they object to carry out a specific act. Although this isn't explicitly stated, I propose that she also finds nurses similar to soldiers in so far as they are be disempowered and subject to constraints such as higher authority; the nurse like the soldier is required to obey orders regardless of personal opinion.

This part of her paper is perhaps the part with most confusions in the internal validity of arguments that she presents. I will be offering more detailed contra arguments to her fundamental assumptions and arguments later, but in this chapter will offer some analysis of this lack of internal validity.

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<sup>30</sup> These are numerous and often concentrate on conscience and abortion, therapeutic male circumcision and other sources that specifically address conscience and healthcare.

<sup>31</sup> See as examples, Cantor & Baum (2004); Dickens (2009).

The first confusion in her work occurs when she makes comparison between nursing and the military, and describes the men who refused to be drafted into the army during the Vietnam war, as similar to nurses facing moral distress and choosing not to act: this is a description of men avoiding becoming soldiers and would better equate to the person who decides not to become a nurse. However, after this error she does also describe soldiers who object to specific wars. These she states are like nurses who object to specific actions in their nursing work. In this section each case will be reported in turn and assessed as to whether or not they are indeed soldiers who object to specific wars as Catlin proposes.

#### Soldiers who conscientiously object and their similarities to nurses who might do the same

My aim in this section is not to investigate the details of military legal action – this is not relevant to the law as it pertains to conscientious objection in health care, and does not reflect the level of analysis presented in Catlin’s paper. The aim at this point is to investigate the way in which Catlin uses reports of some military cases to support her position on conscientious objection and nursing, and to demonstrate that her position on this cannot be fully sustained.

Firstly in the case of Kevin Benderman I was unable to access the website referenced by Catlin, but from further searches it seems that he conscientiously objected to returning to Iraq as a soldier because his experiences on a previous duty there had led him to conclude that all war is wrong (Antiwar.com, 2005a). In

other words, his conscientious objection was to war, rather than a specific war and therefore he would rather not be a soldier. This would equate more accurately to a nurse deciding to no longer be a nurse rather than objecting to specific medical treatment as claimed by Catlin. Unlike the nurse who leaves the profession, the soldier is duty and legally bound to serve his contract.

Sergeant Camilo Mehia (Citizen soldier, 2005) also conscientiously objected to returning to war in Iraq. He claimed conscientious objection on the grounds that he had observed and no longer wished to participate in violations against international law, such as torture of prisoners, that he had observed during his tour of duty in Iraq.

This case also does not equate with Catlin's claim that soldiers sometimes conscientiously object to specific wars. On this occasion she ought to describe a soldier who conscientiously objected to an illegal act, and this would more accurately equate to the nurse who conscientiously objects to an illegal act in healthcare. Such acts are more similar to euthanasia than to overtreatment. Of some interest though, is that the soldier refers to torture in reference to what he saw happening. This echoes the nurse's response, when she feels that patients are tortured by 'futile' treatment. Catlin does not draw comparison here but the perception of being involved in torture must at least in part explain the strong emotional reaction that the nurse experiences in moral distress; clearly torture is an act that is a contradiction to the care and compassion that underpins nursing.

The third soldier that Catlin refers to is Pablo Paredes (Democracy Now, 2005). He objected to the Iraqi war and failed to board a ship bound for war and subsequently was charged and not permitted to claim conscientious objector status. Here Catlin does have an example of a soldier who conscientiously objects to a specific war, however, unlike the nurse, he again objects on the grounds of illegality; that is that the war in Iraq was an illegal war. In both these cases then, Catlin fails to identify the significance of legality of action, and as I have already stated, legality of action is not in question when a doctor prescribes a treatment that is, in the perception of the nurse, one that is overly aggressive or 'futile'.

The last soldier that Catlin refers to is Lt Ehreh Watada. He like the previous soldier objected to the Iraq war based on the fact that the war was illegal and immoral. He perhaps most clearly demonstrates Catlin's proposal that conscientious objection might bring about a change in practice. His speech prior to his court martialing was broadcast and encouraged others to act against the war in Iraq.<sup>32</sup> In this speech he identified his powerlessness to change the course of the war, but presented his conscientious objection and his public articulation of the reasons for it, as an empowering act. The fact that he mentioned morality as well as legality is perhaps also important in the support of Catlin's argument that soldiers and nurses are similar. Although most soldiers object to what they see as illegal acts, these acts can also be wrong because they are immoral, even if recognised by law.

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<sup>32</sup> 'Erhen Watada's Last Speech Before His Court Martial Hearing' is a film that presents his arguments for his decision to conscientiously object. (Watada, 2007)

Perhaps then it could be argued that the nurse is similar to this soldier example, because both are sometimes asked to perform immoral acts that are not necessarily illegal. Furthermore, the nurse may be similar to the soldier when she articulates her reasons for conscientious objection publically and uses the example of her own self sacrifice (from employment) as an encouragement for others to do the same, or to think about and change their practice. Again, I want to highlight though the distinction between the soldiers and nurses. Lt Ehren attempted to resign from the army once he identified his conscientious objection to his perceived illegality of the Iraq war. He was unable to do so and in the end his case was dismissed from court in 2009.

The nurse, unlike the soldier is under no compulsion to remain in her post and contractual agreements with the employer are easily discontinued. Indeed, the literature that describes the exit of nurses from the profession or specific fields of work might fail to acknowledge that this is an acceptable expression of conscientious objection on the part of the nurse, and ought to be perceived in a positive light. Catlin reports the fact that nurses leave their positions but does not indicate that this might indeed be a positive and empowered expression of conscientious objection to involvement in medical specialties where aggressive treatment is the norm.

#### Catlin's proposal for conscience clause in the ANA code of conduct

To finish this theoretical examination of Catlin's work I will summarise the concluding concept that Catlin proposes as the foundation for a development of

the conscientious objection statement that has already been described in the ANA code of conduct.

She describes this concept in three phases: attributes of conscientious objection, antecedents to objecting and consequences of objection and after identification of these, proposes the defining statement:

‘For the nurse, conscientious objection may occur when the nurse interprets that the care that has been assigned for the patient is harmful or causing suffering. The nurse does not wish to provide this form of care and feels sincerely and has felt for some time that this is a question of conscience. The nurse objects to the nature of care orders, willing to assist in other forms of care and not wishing to abandon the patient’ (p.105)

This definition does not fully include the statements within the attributes, antecedents and consequences that are listed in her text (p104), and this means that her definition does not quite include all of her proposals around conscientious objection. They are that the nurse has a duty of non malificence, that the nurse perceives carrying out the act in question as threatening her integrity, that the nurse will not abandon the patient and appropriate coverage is arranged, that the nurse must accept the self consequences and risks of objection and that these might include sanctions such as loss of employment or alternatively bring about a change in practice based on the support of others.

There are some assumptions that are worthy of further consideration. Unlike the case of legally acceptable conscientious objection, where a person is offered protection from punishment, Catlin and the ANA code of conduct make clear that conscientious objection, even though it would be professionally sanctioned, might lead to contractual punishment such as loss of a job. This perhaps reflects the external contextual cause of power imbalance that was identified in chapter one.<sup>33</sup> Furthermore, if nurses are at risk of suffering detrimental outcomes to a sanctioned professional practice, it seems that in addition to this perceived harm to patients, she may be on the receiving end of wrong-doing, should she be forced to carry out an act she believes to be wrong or alternatively, should she receive some punishment for conscientiously objecting.

This position is supported when consideration is given to the choice of soldiers that Catlin made in her paper. None of these soldiers were legally recognised as conscientious objectors, but presumably in Catlin's eyes, they ought to have been.

#### Empirical findings that support Catlin's proposal

Catlin proposes that a concept is not properly verified without a concept analysis; an exercise where a concept is taken to those in clinical practice and its practical currency assessed.

She does not make clear why this hybrid analysis is important, but certainly one can deduce that if nurses do not recognise the concept as being in any way

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<sup>33</sup>See p23.

recognisable to them and to their practice, it might not be useful to practical ethical decision-making. Secondly, although she does not stipulate this, it seems that such an analysis might be used to support the ethical arguments presented; in other words, if nurses agree with the concept as defined by Catlin then this is another reason why it ought to be implemented. Although it is essential for such concepts to be recognised as relevant to nursing practice, the support offered by the 'majority vote' in ethics is not necessarily supportable.

Her research involved questioning sixty-six neonatal and paediatric critical care nurses who worked in intensive care settings. She found that seventy-five percent of them had thought of conscientious objection in relation to their practice and that fifty-two percent would like to object to aggressive interventions that 'do not change outcomes'. Obviously the difficulty here is that nurses might wrongly perceive that outcomes would have been better had treatment been withdrawn, or had been less aggressive. However as Krishna et al. (2010) demonstrated, this isn't necessarily the case. Forty-four percent wanted to object to technologic interventions for twenty two to twenty four week gestational age of newborns or newborns with conditions 'incompatible with life'. Thirty percent stated that they wished to object to pressure from families who would not agree to change to palliative care.

Some of the questions that these nurses were required to answer in relation to their sense of moral distress, do not reflect the difficult nature of care under such extreme circumstances and instead bypass this complexity with some statements that specify clear wrong-doing. Although I have no wish to suggest that



aggressive treatment of patients is always right, it is hard to accept that the vast majority of doctors instigate medical treatments where it is known for certain that there will be no change in outcome, and where that outcome is presumably death. Indeed, perhaps she gains such a high percentage support for these incidents because she frames ethical scenarios too simply and in this instance at least, wrongly, because the 'no change in outcome' is stated as a fact rather than a perception of 'fact'.

It is disappointing that Catlin does not take her practical considerations about conscientious objection further. As can be seen, the numbers of nurses wishing to conscientiously object are high - one can presume around a third to a half of any single shift on duty, should her sample be reflective of all nurses – will be inclined to conscientiously object to care of the kind of patients that have been identified. The data does not specify whether or not the same nurses repeatedly wish to conscientiously object to the variety of conditions described. If this is not the case, then surely if a mixture of patient conditions are present on a ward or unit, then the percentage of nurses wishing to conscientiously object might be higher than this, if the sum of nurses and patient conditions are added together. Catlin does not address the fact that should these nurses take up a right to conscientiously object, with the percentages identified, the smooth running of a unit or ward and the delivery of nursing care to resident patients could be compromised, at least in so far as a focus of activity would become finding out who is willing or not willing to cover care of a specific patient.

It is worth noting here that the wrong-doing identified in Catlin's empirical work is not identical to that highlighted in her theoretical discussions. For example, the treatment of twenty two to twenty four week babies is a contentious subject in its own right, because as has been discussed earlier, such babies are on the cusp of viability and are at high risk of permanent disability. This is not simply the denial of palliative care. Should nurses conscientiously object to treating these patients on this basis, it seems to me that Catlin needs to specify severe disability as a harm to which nurses can conscientiously object to causing. Of course, should living with severe disability be identified as a consequence that nurses value as a harm that is worse than death, a Pandora's box is opened where the fundamental principles of nursing care: compassion and the promotion of dignity of all, including those who are seriously disabled, that is the basis of nursing, (Chambers and Ryder, 2009) is brought into question. This is just one example of where lack of detailed examination of the rational basis for moral distress, can lead nurses to conclusions about right<sup>34</sup> that might not be so right after all.

Finally Catlin found from her work that around forty five percent of nurses had acted in a way that could be considered a personal conscientious objection without formally objecting. Of these, seventeen percent had voiced their opinions to the physician, two percent had documented disagreement on a chart, ten percent had asked another nurse to take the assignment and three percent had called an ethics committee or called in another physician and ten percent overtly or covertly refused to follow an order. It is questionable whether or not the above

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<sup>34</sup> In this case the rightness of non-treatment of very young neonates on the basis of disabled outcome for some.

actions truly constitute conscientious objection, even though the nurses seem to have framed it in this way. Those who asked another nurse to take their assignment might well have conscientiously objected, but it could alternatively have been that instead they were in a state of moral distress, and given the emotional nature of this state, other factors could have led them to asking for a change in assignment such as feeling emotionally burnt out. However, the other cases do not seem to accurately describe conscientious objection: questioning an order, or recording disagreement could be acts that are more accurately described as advocacy or ensuring that one is legally covered should a case end up in court. The calling in of another physician could reflect an outright clinical disagreement or demonstrate a nurse who questions the competence of the attending doctor. Indeed, all of the above scenarios could result from a clash of professional opinions rather than truly reflect the nature of conscience, as it is generally understood.

The remaining half of nurses had never objected and this group stated that they had put aside their personal beliefs and followed the doctor's request although all respondents reported that they felt the need to object to therapies that did not change the underlying condition of a dying patient and wanted guidance from nursing organisations on how to do so.

## Conclusion

In this chapter the implicit and explicit arguments that Catlin presents in her proposal that conscientious objection to the denial of palliative care ought to be

formally recognised in the ANA code of nursing conduct. As has already been explained, I will extrapolate this to the UK code of nursing conduct and the next chapters will examine the theoretical, legal and professional arguments that support and refute Catlin's position.

Some initial analysis of her proposals have been made and despite the problems identified with her work, the similarities between soldiers and nurses deserves further exploration. The identification of conscientious objection as the mode by which the nurse expresses her dissent or disagreement with the doctor needs further analysis; is it truly a conscientious objection or is it a professional disagreement? Finally, it seems that the nature of right and wrong that is faced in situations of moral distress, is far from certain.

Chapter Four: *The philosophy of conscience and its application to conscientious objection to 'futile' orders.*

Introduction

In this chapter and those that follow, specific perspectives and arguments about conscience and conscientious objection that will exclude some well-trodden approaches that are readily accessible.<sup>35</sup> This is because the aim of this thesis is to present new arguments that are not present in the current literature, but also because conscientious objection in the case of the nurse who disagrees with a doctor's orders, is one where the arguments that already exist do not necessarily capture the situation fully. In particular, the primary and secondary harms that are identified in moral distress are not addressed. Unlike the doctor or nurse who objects to participating in an abortion or blood transfusion, this is not a simple case of one person's personal values, rights and professional obligations conflicts with another's choice and legal right to pursue that choice. Furthermore, with conscientious objection to a doctor's orders, there are two relationships; the nurse to the doctor and the nurse to the patient. The values that the nurse expresses might be conscientious, however they might be excluded from what is commonly termed 'conscience' because the doctor who treats a patient aggressively, might lead to the nurse objecting on the grounds of professional rather than personal values. These questions will be addressed over the next three chapters, beginning with a philosophical examination of

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<sup>35</sup> See for example Wicclair's (2011) book on conscientious objection in health care that is the most recent title to give an excellent review and comprehensive presentation of arguments on this topic.

conscience in this chapter, moving to a legal examination and finally an examination of professional codes of conduct in chapter six.

In this chapter two main premises presented by Catlin will be examined. The first is that conscience is an important source to identify right and wrong action. The second is that the nurse is justified in conscientious objection under the circumstances described by Catlin, because she is asked to participate in primary harm to patients. Kolnai (1958) has been chosen as a primary source to examine these questions because his paper on erroneous conscience gives a solid philosophical enquiry into the nature of conscience that is not commonly referred to in current papers. He also acts as a strong source to deal with the strongest objection to my position; that is that nurses who are not given the opportunity to conscientiously object may end up submitting to orders that are atrocious. This will be dealt with more fully in chapter seven.

#### An intuitive grasp of conscience.

Before examination of the literature, it is helpful to explore an intuitive grasp of conscience, after all surely if conscience is an inherent or learned ability to identify right and wrong action, its definition must be inherently accessible and at least partially consistent with the literature, if it is something we can all claim to possess. In meeting this end it is perhaps useful to consider what the absence of conscience would be like. In such circumstances, persons would perform actions that do not in any way take into account the harm that might be done to others; those 'others' being for example, fellow human beings, non human

animals or less easily identified objects such as 'the environment'. Presumably, such an individual would act in a way that satisfies his own whims, wants and needs. Clearly, such an individual, and a world made up of the same, would be one that could not function coherently.

I suppose a caveat to this is that the world managed to function coherently for millennia without moral beings inhabiting it, if one is to accept the assumption that animals are amoral.<sup>36</sup> However, whether or not non-human animals are moral or not, they do not have the capacity to effect the environment as profoundly as do humans. Human intelligence has shown itself to be capable of causing significant harms to our own species in war, and more lately we have become aware of a more general harm in the form of environmental damage such as deforestation and global.

Whatever the case, one has to conclude that given the potential for harm and given the ability of humans to perceive that harm, right and wrong has to enter into the reckoning when any competent individual contemplates an action with potential to cause harm to another. In other words we are essentially moral, and the inward sense of whether or not we do right or wrong - that is conscience - is at least partly responsible for moral action.<sup>37</sup> Conscience therefore can

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<sup>36</sup> By 'coherently' I mean that evolution has successfully maintained life prior to the arrival of human beings. Therefore, if humans are the only organisms to have morality, morality is not necessary for the continuation of life. However, if empathy is at the core of morality as Slote (2007) argues, then amorality is not necessarily a characteristic that only humans possess. For an emotive example see 'Female Elephants Save Drowning Baby' .(Year unknown)

<sup>37</sup> Other influences on our capacity to act morally are features such as genetics and environmental factors that are outside of our control. (Dickenson, 2007)

reasonably be identified as the source of our sense of moral responsibility and affects us in such a way as to perform morally responsible actions. It is an essential prerequisite to moral agency, and acting contrary to our conscience disturbs our sense of integrity.

It seems that conscience can be good thing for the person on the receiving end of the conscientious individual's actions except of course, that this is dependent on the action that the conscience dictates ought to be done. Once that action becomes the object that impacts on others and therefore open to judgement by others, it brings with it all the irresolvable problems and differing points of view that fill ethical and philosophical journals and present some of the most challenging cases in courts of law.

This reflects the reality that what is right is not so easily identified because the nature of right and wrong is not something that is totally accessible to us. Philosophers do not agree upon its absolute nature.<sup>38</sup> Is it an unchanging truth that we somehow have to decipher by the use of reason? Is it an ideology constructed and agreed upon by specific groups of individuals in specific times, without form or solidity other than in the minds of those that perceive it? Indeed, the justification to restrict a person's right to express their conscience is surely reliant on the premise that right and wrong are objective, or at least legally recognised, truths beyond which a person cannot do what exactly as his conscience dictates, because one person's conscience might not be congruent with another's. Such matters are beyond the scope of this thesis, but they are

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<sup>38</sup> Rist (2002) makes an in depth exploration of this question



worth some consideration because they highlight some of the difficulties we face when considering the individual rights to express conscience, and that if not recognised, can lead to overly simplistic arguments about how an individual ought to be able to express his conscience, that tends to bypass the absolute nature of the action in question. In so doing there is a danger of leaping to the focus on self, and one person's right to express their conscience *versus* another person's right to act in a contrary manner<sup>39</sup>.

In this thesis this second aspect of conscience will be kept in mind and indeed if anything, take precedence. In other words, the end result of conscience - the action and its consequences - is as much an essential element to conscience as is the self.<sup>40</sup> My preference with regard to the underlying philosophy and the nature of moral truth is one that recognises that moral truth is 'out there'. This concept of objective moral truth is important for resolving the problems brought by moral distress and also for my reasons for opposing Catlin's position that conscientious objection ought to be permissible for nurses. This will be equally as important as the nurse feeling what she is doing is wrong, is whether or not what she is doing is in fact wrong.<sup>41</sup> As far as I'm concerned, it is only if the latter

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<sup>39</sup> See for example papers that discuss conscientious objection and delivery of abortion procedures and the dispensing of the contraceptive or post coital contraceptive pill. These debates tend to centre on rights of the patient to receive a legally permissible procedure *versus* the rights of professionals to protect their sense of integrity and good conscience. These debates are perhaps more active in the US, although the British Pharmaceutical Association recently upheld guidelines to allow pharmacists to conscientiously refuse to dispense hormonal contraception (BBCa, 2010; General Pharmaceutical Council, 2010.)

<sup>40</sup> Please note that 'self' refers to both integrity of self, and autonomy with regard to responsibility and control over one's actions.

<sup>41</sup> If objective wrong-doing is identified, then it might be that the nurse is justified and can be professionally supported to conscientiously object.

aspect of conscience – the act - involves objectively observable wrongdoing, that the question of conscientious objection becomes a possible justifiable resolution to the problem in question. As shall be seen, even in the case of definite wrongdoing, it might be that conscientious objection is not the ideal solution.

### The Nature of Conscience and its importance for nursing.

This intuitive sense of conscience is supported by much of the literature, and Kolnai (1958) faces head on the problems associated with conflicting senses of what is understood to be right, as it exists in one individual compared to the next. As shall be seen, his account is particularly useful for this thesis. Others add ideas that are also worthy of consideration.

According to Catlin, conscience can be understood as an internal moral sense of what is right and wrong. Kolnai supports this position, stating that conscience is the:

‘moral awareness...self criticism, remorse, warning, acquittal or approbation in reference to one’s own conduct: past, present or tentatively planned. Conscience means further moral judgment in the shaping of one’s conduct.’ (p 175)

He takes conscience further than the rather generalised definitions chosen by Catlin, and makes one aware that it encompasses not just our convictions and obligations, but our motivation and most importantly that it directly connects

with our actions: it is something dynamic and has real impact on the world around us. Kolnai has some warnings to make about conscience that will be returned to later, but it should be noted that many, including myself, see conscience to be an important feature of human morality.

Some authors view conscience slightly differently, for example, Nussbaum (2008) expands the definition of conscience. She does not see it solely as a capacity for agency and choice, both of which are included in Kolnai's definition, but expands it to the search for meaning, and unlike some philosophers, includes emotion and imagination. Lutzen et al. (2003) certainly support this view of conscience when they report that nurses and physicians often refer to conscience when narrating meaning in ethically difficult situations. This extension of conscience into the spiritual realm captures some of the experience of moral distress: studies have found that moral distress correlates with a sense of meaninglessness (Sorlie et al. 2003). and indeed those that nurses care for at the end of life also need to find a sense of meaning if they are to have a good death (Kastenbaum et al., 1993).

For practical purposes, Nussbaum's view is not useful for identifying when or how a nurse might be justified in a decision to conscientiously object to doctors' orders: the exercising of such a right requires an articulation that can be clearly understood by others. However, the sense of meaningless that accompanies moral distress, is certainly deserving of attention when conscience is framed in this way, and will be useful in chapter seven, when practical resolutions that exclude conscientious objection are offered.

The concept of conscience has withstood the test of time and there is a long-standing respect for it that is found in theology as well as philosophy. For example, Thomas Aquinas, despite a conservative view on church authority, argued that ultimately individuals had to follow the inner light of their conscience, even if it was in opposition to church authority. Catholic theologians continue to argue that ignoring the conscience leads to hardness of heart where one no longer feels guilt or the need for repentance (Lawrence et al., 2007). Guilt has also been found to correlate with experiences of moral distress, and perhaps the withdrawal from patients that nurses sometimes make in response to moral distress, is an expression of this sense of guilt and disharmony. Indeed, perhaps some who no longer feel or respond to moral distress have acquired the 'hardness of heart' that theologians propose is a response to the inability or choice not to heed the voice of conscience. Obviously the concern for nurses is not so much a damaged relationship with God, but rather a damaged relationship with one's patients or with oneself. The ideal resolution to moral distress then, could be one where the sense of compassion and connection that the nurse has with her patient is sustained.

Similarly, to the theologians, Cannold (1994) states that to ignore the conscience seems to have a deleterious effect on one's ability to be an integrated person, who is able to interact with others in an integrated way that leads to internal disharmony of the self. Self it seems, is central to conscience, and in a mirror image that reflects a co-dependent relationship to this, integrity and harmony of the self is an essential element that allows a sense of conscience to be sustained.

This sense of integrity is important with regard to conscience and Wicclair (2000), a philosopher who has written extensively on conscience and conscientious objection in medicine, has argued that the most promising justification for HCPs to be able to conscientiously object is that it protects moral integrity, and that maintaining good conscience is central to self respect and avoidance of self betrayal.

Further to this, as I have previously highlighted, and as Kolnai's definition supports, autonomy and a sense of moral responsibility for one's actions are intimately entwined with conscience and also need preservation. Juthberg et al. (2010) would certainly support this position, stating that without conscience and the ability to express it, there is no moral responsibility. Furthermore, a sense of individual moral responsibility is congruent with the valued Western concept of autonomy - the idea that each person is essentially an individual with a free will and the freedom to express his will.

This sense of responsibility is instilled in nurses who are urged to be responsible, knowledgeable doers who are accountable for their actions (NMC 2008a, McGann, 2004) The GoodWork© Project that examined the characteristics of individuals and excellence in work, and that involved fifty researchers at seven universities, identified that a sense of moral responsibility was closely associated with one's sense of moral identity: those with a strong sense of moral identity also had a sense of responsibility (Damon & Bronk , 2007). It was also found that this sense of responsibility for one's actions, is essential to carrying out one's

work diligently, and without them there is unlikely to be excellence (Gardner, 2007).

These are valid reasons to preserve the nurse's sense of good conscience and to avoid the opposite state that is created in moral distress or troubled conscience: to erode a nurse's sense of good conscience must also risk eroding this sense of responsibility and accountability, an end result that would be a retrograde step for the nursing profession and for the individual patient who is nursed. In this sense, already one can see how conscience is an important collective experience for the nursing profession. Because conscience links to responsibility, it links to the autonomy required to exercise responsibility. The road to nursing becoming (what is presented by nurses at least) an autonomous profession, has relied upon winning battles associated with gaining these facets and becoming recognised as a profession separate to medicine (Rafferty 1996, Rafferty et al. 1997). This road to what might be termed autonomy, has been one in which prejudice has had to be overcome, such as the identification of nurses with female stereotypes, and that has lent heavily from feminist ideology in its development, particularly from the 1970s to the 1980s (Hoffman, 1991.; Webb 2002). This feminist stance has been relatively defensive in nature (Chinn, 1995) and not always without conflict.<sup>42</sup> Carol Gilligan's reinterpretation of ethics provided a new road for feminist influence on nursing that will be discussed in chapter seven (Gilligan, 1982).

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<sup>42</sup> Malka draws attention to the uneasy relationship that nursing has with feminism when she describes a Pittsburgh feminist asking 'Why a nurse and not a doctor?'.

Within these reasons, it ought to be noted that there are potentially three ends identified, that are worthy of preservation. Firstly there is the end of moral integrity itself. Secondly there is the result of that integrity; the good work or specifically in the case of nursing, the good nursing care that the patient receives. Finally, there is the preservation of the profession of nursing whose existence depends on its identity – both professional and moral (if these are to be separated). All of these ends are important, but often in discussions about conscience, the end for the patient is overlooked as the self or the profession is attended to. This will be returned to later.

So far then, there is solid support for Catlin's position in so far as a sense of good conscience for the nurse is something that ought to be preserved. Catlin isn't clear about how nurses' expression of conscience, or conscientious objection, ought to impact on the individual patients they serve. However, the essential nature of this expression, ought to be directly linked to the sense of responsibility, striving for excellence and diligent working that is expressed in the state of good conscience and that results in a good end point for patients. That conscientious objection is a means to achieving a good end for patients is questionable.<sup>43</sup>

In conclusion then, conscience can be seen as a four-fold object. Firstly there is the sense of moral awareness that is the motivating and self-critical faculty required for ethical living and its relation to moral integrity. Secondly there is the action that results from conscience, that I argue is as much a constituent of

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<sup>43</sup> Further consideration of this issue will be made in chapter six

conscience worthy of as much consideration as is the preservation of sense of integrity. Thirdly is the capacity to express one's conscience and to have full responsibility for the causal effects of one's actions as is identified by autonomy. Finally, it seems that conscience might be intimately linked to a sense of meaning and purpose.<sup>44</sup>

### Conscience is by its nature erroneous

So far it seems that conscience is a good thing. However, it is not so simple as that and indeed, conscientious objection in the case of HCPs is even more questionable, as Savulescu (2006) draws attention to, conscience can be an excuse for vice, and more importantly, an excuse not to do one's duty. He argues that if conscientious objection is a contradiction of that duty, then it is wrong and immoral. Kolnai offers further analysis of conscience that brings to question the rightness of nurses refusing to carrying out a doctor's order, under Catlin's conditions. This leads to a serious objection to Catlin's position that is based on the premise that conscience is not a reliable source for identifying right and wrong action. In Kolnai's words, the conscience is erroneous.

### Kolnai's Position

Kolnai, sees conscience as moral awareness. Based on his moral principles or values, the agent has a sense of what it is right to do or not do. His conscience is

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<sup>44</sup> There is contention about whether or not personal and professional meaning and purpose can be considered as an expression of conscience. This will be explored in chapter six.



responsible for guarding his chosen actions and relates not only to universal norms, but also to translation of those norms in to practice in actual circumstances.

Although he admits that we have an intuitive tendency to regard conscience he identifies a problem:

‘We expect a man to behave rightly, rather than merely appraise rightly, or merely behave according to his appraisal, and this we consider ‘sinning against the light’ essentially guilty, but also attach a moral disvalue to a person’s following his errant lights’  
(p172)

This problem of conscience potentially being incorrect in its appraisal of right or wrong, has not been discussed in the discourse on moral distress, except indirectly by the recent paper by Repenshek (2009) who argues that nurses perceive wrong-doing in situations that are in fact morally ambiguous.

Kolnai proposes that conscience cannot be relied upon to consistently and correctly identify right and wrong action. He states that ‘conscience’ therefore must always be considered erroneous. As far as he is concerned conscience is synonymous with ‘erroneous conscience.’ :

‘Conscience that cannot hope to be correct , and ....cannot fear to be erroneous, is not Conscience in the ... dignified sense of

moral self-criticism, judgement and belief – which essentially aspires to truth and tries to escape from error, and in fact expresses the agent's endeavour to ponder and argue his decisions...in the open court of objective morality.' (p.179)

He cites examples to support his position such as how some individuals can be overly scrupulous about the wrongness of their actions, and perhaps more convincingly, he describes how the same individual will judge the moral quality of his actions differently over time: even though the nature of the act remains the same, the conscience it seems is malleable and judges it differently.<sup>45</sup> This is supported by empirical evidence. For example Cronqvist (2004) in her analysis of nurses' experiences of ethical difficulties in ICU, found that nurses often changed perspectives within the same interview, such as the nurse who was morally distressed at the delivery of surgical care to an eighty-five year old patient. She stated within the interview that this patient ought not to have been treated, but then commented after reflection, that in her experience, she had seen such patients recover, and that perhaps given this fact, her initial judgment was incorrect.

That conscience is by its nature necessarily erroneous, Kolnai argues, does not mean that it ought not be respected or valued. On the contrary, Kolnai states that conscience deserves to be respected, because the best we can achieve is to allow

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<sup>45</sup> Hardwig (1997) offers a different perspective that supports this position in his discussion about autobiography, biography in the sphere of narrative ethics. He points out the malleability of one's interests, beliefs, desires and motives and a person's inability to truly identify them.

an agent to always act in such a way that is congruent with his erroneous conscience. Furthermore, not only do we allow an agent to act in this way, we admire him for doing so, even if his views differ to our own. Of course this is not so simple as it first appears, given that some people will have a conscience that not only differs to our own, but that is in direct and violent conflict with it.

It should be noted that some misunderstanding of Kolnai's position can arise from the use of the word 'erroneous'. He does not mean by this that conscience is never right and wholly untrustworthy. This would not be congruent with his wish to promote conscience as a dignified aspect of human moral endeavour. Indeed, for his understanding of conscience in general, fallible is perhaps a better word to use than 'erroneous'. Why he chooses the word 'erroneous' over 'fallible' is not explicitly discussed in his paper, but it seems that this arises from the subject he focuses on for much of his paper; that is the investigation of when conscience can be truly identified as 'erroneous'; that is when moral agents claim to use their conscience in directing them towards wrong-doing that can enter into the world of atrocity, or as shall be argued, error is made on the basis of misinformation<sup>46</sup>

Kolnai sets to resolve the ambiguity that we ought to admire a person who follows his conscience, but that this can lead the same person to commit acts that are morally reprehensible and absolutely require intervention to stop them, by

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<sup>46</sup> In this thesis, the word 'erroneous' will be used to accurately reflect Kolnai's presentation, but the reader can understand conscience in a general sense as 'fallible', except under conditions where gross wrong-doing has occurred in the case for example of 'overlain conscience'.

recourse to the idea of 'overlain conscience'. This is where the agent takes a non-moral absolute as the source of his conscience. As an example of this he cites the atrocities committed by Nazis during World War Two, where totalitarian ideology became the source of morality that contradicted longstanding consensus about the morality of killing, or the status of human beings. It is interesting to note how an academic paper can result from the challenges of the time, but clearly the same questions about the ability of humans to commit atrocity seemingly with clear consciences is still relevant today. Such atrocities have included the actions of doctors and nurses (Shields, 2003).

This ambiguity also brings to question the nature of integrity and the fact that it is not seen solely as a sense of personal wholeness, but as a sense of completeness and wholeness that is virtuous in terms of 'soundness' or 'sinlessness' 'uprightness' 'honesty', 'sincerity', 'uncorrupted virtue' (Gillon 1985) and that is incompatible with the 'integrity' displayed by those who committed atrocities in Nazi Germany.<sup>47</sup> At this point it might seem that such extreme acts are not relevant to the situations described in this thesis, but they will become relevant later on.

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<sup>47</sup> An interesting point for further exploration of the moral conundrum that arises from a sense of good conscience, personal integrity and virtue combined with atrocious or morally reprehensible acts are the films 'Downfall' (2004) directed by Hirschbigel and 'Pierrepont: The last hangman' (2006) directed by Shergold. In both these films main characters can be seen displaying virtues such as compassion, sacrifice of self, loyalty to another or to the state, whilst also carrying out or supporting acts such as mass extermination of Jews or hanging convicted criminals. I will return to this later, but contradictory to this, others can be seen to be carrying out atrocious acts with good virtue but also without necessarily being deemed morally reprehensible, in the film 'Schindler's list' (1993) directed by Spielberg, when doctors and nurses euthanize patients prior to the arrival of German soldiers and the known event of execution which would follow (what makes this different is the implied consent of the patients.)

Kolnai makes an almost aside comment that is significant for my position on moral distress; that is that the nature of error in conscience can be erroneous:

‘in the trivial sense of conscience as moral decision *hic et nunc*,  
misinformed as to the facts’ (p176)

This description of the ‘trivial sense’ of being misinformed to the facts is uncomfortable to read, but it is the first objection to be raised in response to Catlin, having already called into question the degree to which we can trust our consciences for identifying accurately, right from wrong. That is that moral distress arises in nurses partly due to the fact that they are lacking or misinformed of the facts that result in them judging right and wrong incorrectly.

Kolnai proposes that in the identification of whether or not a conscience is acceptably erroneous or is instead unacceptably erroneous, that it is essential to draw on consensus as a guide. So for example, in Nazi Germany, those who supported and committed atrocities such as extermination of Jews and euthanasia of learning disabled patients, did not hold moral values that are by consensus deemed to be right: there is a long standing history in philosophy and religion that killing of humans is wrong except under exceptional circumstances, and certainly not because one human has a inherent characteristic that justifies the act. Such consensus may of course be presented as a form of relativism and

dependent on a society at a certain time.<sup>48</sup> Nevertheless, whether or not one has a relativistic stance, it seems reasonable to accept longstanding consensus that has stood the test of time and events. For the relativist, there isn't really anything better anyway, and for the one who accepts universal truths, consensus is a route to identify those truths, through reason and for me at least, emotion.

Kolnai states:

'That consensus is not ... exhaustively represented in any specified system, creed, person or collective. It is laid down in the universe of moral intuitions, traditions and codes, which are necessarily incomplete and fraught with ambiguities' (p. 194)

As far as he is concerned the agent involved in atrocious acts, does not have an erroneous conscience in common with the rest of humanity, but rather, has what he terms an 'overlain conscience' (p.188) This is when an individual adapts their conscience to a non moral absolute. He states that this is a human entity, communal or individual, where an institution or ideology usurps fundamental morality. Nazism was an example in Kolnai's time, but perhaps the child abuse scandal in the Roman Catholic Church, is a modern day example.<sup>49</sup> To submit

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<sup>48</sup> For example, there is no doubt that there are some grave issues in the Western world over which we can't reach consensus such as abortion or execution of murderers.

<sup>49</sup> A significant cause of the child abuse scandal was the prioritisation of the scandal and subsequent damage that might be caused to the institution of the church, over the safety of children and bringing offending priests to justice. (Doyle, 2003)

fully to an overlain conscience means in Kolnai's eyes, that conscience becomes an absent force.

He presents two characteristics of conscience that serve to contradict Catlin's position. The first is that conscience is erroneous and the second is that conscience must be expressed within a moral consensus. These will be discussed in turn and make my first objections to conscientious objection as is presented by Catlin.

#### Objection to Catlin: Misinformed of the facts.

Nurses are likely to experience an erroneous conscience when morally distressed because the empirical and ethical grounds on which they base their judgments, particularly of primary harm, are often incorrect, or else lack broader contextual understanding.

This misinformation rests in three forms. Firstly, that nurses are misinformed of the empirical facts, secondly that nurses are psychologically inclined to judge the intention of doctors more harshly than is justified, and thirdly, that nurses lack a broad ethical perspective on which to make ethical judgement on individual cases in the context of medical care delivered to many. Each will be examined in turn.

As has already been stated, a person's conscience can be erroneous in the trivial sense where the individual is misinformed of the facts. This is relevant to the

case of moral distress in nursing. Some of the research into moral distress indicates that more experienced nurses suffer more extreme moral distress, or suffer it more frequently.<sup>50</sup> It is implied that more experienced nurses have greater knowledge that they are constrained from applying to the patients under their care and subsequently suffer more extreme distress. There is though, no evidence to demonstrate that such nurses are more accurate in their eventual accuracy in the prediction of consequences. Although such nurses do acquire a greater knowledge about nursing and medical care, perhaps the moral distress is more extreme not because of this, but because they have experienced similar circumstances more times; they too suffer and become 'burned out' with this repeated exposure, that is particularly difficult because of their sustained proximity to patients and their suffering (Ferral and Coyle, 2008, pp9-19).

There is an unexpressed assumption in Catlin's work that nurses at least on the substantial numbers of occasions where they suffer moral distress, know better than doctors whether or not a patient ought to be aggressively treated, or instead their symptoms palliated. In agreement with this assumption, it has been found that nurses tend to make more pessimistic and accurate predictions about whether or not a patient will die under 'futile' treatment (Frick et al., 2003). However, contrary to this, they are not accurate in predicting out of the few who will survive, which patients these are. Indeed, medical models don't yet exist that are able to do this (Hamrick & Blackhall, 2007). In further support of this position, it has been found that when doctors are questioned about aggressive medical care, that they cited examples of nurses who strongly disapproved of

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<sup>50</sup> See p32.



aggressive medical care for one patient, only to find later that that the same patient had survived (Gill, 2005; Gustaitis and Young, 1983).

Added to this, some empirical research has found that nurses are misinformed of clinical facts. For example, Antommaria & Bratton (2008) found that nurses were distressed when brain dead patients were about to become organ donors. The nurses were found to not understand the physiological facts that are employed to justify removal of organs from a living body. Nurses' lack of biological knowledge has received a lot of attention in nursing education and even intensive care nurses have been found not to apply biology to nursing care, relying instead on policies and procedures to direct their clinical decision-making (O'Reilly, 2004; McVicar et al., 2010).

De Wolf Boseck (2005) further supports this position. He describes an ethics consultation in the US where the nurse phoned because she identified that a doctor had refused to give pain medication to a patient in ICU. She was advised to call the director of the ICU and having done this, the care provided was not changed, although she felt a lot better afterwards. Obviously the nurse was right to pursue the concern she had about pain medication, but in this instance her moral distress was misplaced because as Cochran (2004) pointed out in his response to this paper, the nurse had failed to understand that pain medication might have been harmful to her patient because the patient was being weaned from the ventilator. That is, doctors will sometimes allow for immediately distressing effects such as pain to meet the better end: in this instance no longer being dependent on a ventilator.

Nurses are psychologically primed to view the intentions of doctors as morally suspect.

In further support of this position, psychologists have found that when negative consequences occur as a result of an action, observers are more likely to judge this effect as intended (Jansen and Fogel 2009). Therefore nurses are perhaps more likely to judge doctors as having wrong intentions - such as lack of care to offer palliative care - when they see one after the other patient die. Supporting this view, Gustaitis and Young (1983) report in their journalistic exposition of a neonatal intensive care unit in the US how doctors found the nurses frequently harsh in their manner towards them when such decisions were made. The evidence indicates that not only do people tend to judge 'bad' intentions in the manner described, but also, when there is a positive outcome - for example the patient who survives seemingly against the odds - observers are more likely to judge it as unintentional in comparison to negative outcome. This paradoxical thinking that has been demonstrated most likely is congruent with nurse's experiences in moral distress and is indicative not only of an erroneous thinking but also must compound the negative emotional consequences. In other words, nurses will tend to ascribe negative intentions to doctors as they make decisions to treat aggressively, but also, even when the patient survives, nurses will fail to see this as a direct effect of the doctor's good initial intentions. This psychological effect is another form of erroneous appraisal, and given the tendency to judge intention paradoxically, it is another reason to challenge that conscientious objection of nurses to doctors' orders in 'futile' circumstances is a good thing, because once the nurse has observed undesired consequences of

medical decisions, she is more likely to erroneously judge the intentions of doctors' actions more harshly.

#### Nurses have a particular moral perspective that lacks broad context

Finally, nurses can be erroneous in their form of ethical reasoning when faced with situations that cause moral distress. There is undoubtedly an ethical question to be answered about whether or not the suffering caused by aggressive medical treatment is worth the survival rate of patients, or whether all aggressive medical treatments ought instead to be withheld to prevent suffering, whilst knowing that some will die as a result of this.

As has been stated previously, the empirical evidence on moral distress does not indicate this broader or consequentialist perspective, but rather, it seems that nurses are very much affected by the single patient in front of them. Indeed nurses that suffer moral distress have been found to reason by an ethics of care approach more than other frameworks such as justice (Nathaniel, 2006). This method of ethical analysis is closely associated with proximity and emotional involvement and lacks principled analysis (Slote, 2007). For example, nurses frame their descriptions around moral distress as one of intimate relationship to the patient as I have already described in previous chapters. The alternate broader perspective in terms of numbers of patients and a projection of these numbers into the future is lacking in nurses' evaluation of the situations they are faced with. As has already been indicated, the nurse will tend to be accurate and

pessimistic in her assessment of the individual patient, but unable to predict which 'futile' case will turn out well.

It has been found that the proximity of the nurse to the patient and the patient's bedside and associated suffering has a strong association with moral distress.<sup>51</sup> The nurse unlike the doctor or indeed other HCPs does not have the opportunity to leave the bedside. Unless one has been a nurse it is difficult to appreciate the degree of this 'attachment'. The ward or intensive care nurse can't make a visit to the toilet or take a break until she has assured that a colleague covers her patients. There is no set pattern to the day where she has a predictable lunch break, can take regular periods of time for short alternative activities such as attending a seminar, teaching session, seeing previous patients in outpatients or other organisational activities such as review of policies. Her physical immersion in the current status of her relatively small number of patients is for most of her working time, total. This results in a narrow ethical perspective that fails to see the consequential justification of the suffering of many to save the few and as has been shown, she will have a tendency to judge the intention of doctors in such circumstances negatively.

It is beyond the scope of this thesis to consider the ethical arguments about whether or not aggressive medical treatment ought to be promoted and funded by the NHS. What is of significance though is that there is a consensus that such treatment is accepted and promoted and that this is supportable by literature. Yes the introduction of palliative care into the acute or critical care setting ought

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<sup>51</sup> See p26.

to be implemented (Nelson et al., 2006; Smith et al., 2003, Mularski et al., 2006, Lorenz et al. 2008) but even so, patients will still undergo aggressive treatment and will not survive it; until reliable predictors exist for individual cases, this will be the case if saving of lives is to be valued. The empirical evidence supports that lives are saved under aggressive conditions. For example, Singer et al. (2010) found that veterans treated in high intensity intensive care units, where the nature of treatment would be highly aggressive in nature, had a mortality rate of twenty seven percent as opposed to forty percent in a low intensity setting. Powell et al. (2009) likewise found that treatment of critically ill HIV patients with retrovirals showed an epidemiological shift over four years, where patient survival indicators were found to be on the increase. Van Gestal et al. (2010) challenges readers with the fact that in a study of ventilated neurologically impaired children, only around half had a one year non complicated survival after ventilation. However, they argue that such an end result could not be considered futile.

Such statistics are relevant to the provision of aggressive medical treatment, but there is no evidence in the literature on nurses who are morally distressed to indicate that nurses use such consequentialist reasoning to help alleviate the sense that they participate in wrong-doing.

Nurses are not ignorant, or unable to understand the reasoning behind medical decisions, nor unable to contribute to medical decision and on occasions to identify treatments that a doctor has not thought of and that can improve patient outcomes. However, nurses do not undergo medical education, do not generally

attend medical conferences that address detailed information about new medical treatments, their efficacies and survival statistics. Their understanding of bioscience and application to clinical practice has been demonstrated to be weak (O'Reilly, 2004)<sup>52</sup>. This does not mean that nurses are lacking knowledge that they can apply to situations based on experience, or apply protocols. However it does mean that in complex clinical circumstances that are unusual, they do not necessarily have the ability to interpret complex information and predict how it might impact on physiological reactions. Although nurses might ethically disagree with doctors about whether or not the suffering of the many is worth the saving of the few, clinically, they are not as well placed to use empirical information to direct patient care under the former premise.

Finally, whether or not the nurse is right about a medical decision under conditions of moral distress and moral ambiguity about whether or not a particular patient ought to be treated or not, when nurses take on their professional role they concede to a public and contractual consensus (and associated obligations) that they are not the professional group to have final authority and medical decision-making responsibility. To conscientiously object to doctors' orders under the conditions described by Catlin would in effect mean that nurses were assuming this responsibility, at least in so far as they could refuse to participate.

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<sup>52</sup> My experience of a teacher of bioscience to both pre and post registration nurses supports this.

There is no literature that evaluates what non-nurses think about nurses conscientiously objecting to carrying out doctors' orders under these conditions. Such research ought to be carried out and may bring new light to this debate. For now though, it seems likely that nurses, like any other professional, are expected to provide a defined service to others. Although nurses often disagree with doctors, and conversations and alterations in treatment often result from this, it is doubtful that society at large would concede that nurses ought to be able to conscientiously object to medical orders, specifically because society by consensus has given responsibility for medical treatment to doctors. Indeed, the fact that outsiders do not tend to see any ethical conundrum for the nurse who follows doctors' orders demonstrates that this view is prevalent.<sup>53</sup> The nurse is not recognised as a healer in the way that the doctor is.<sup>54</sup> She is rather, a supporter of the doctor and responsible for provision of nursing care to the patient, independently of and in conjunction with the medical care she receives orders to deliver. Such a view runs in direct contradiction to nursing literature that presents the nurse as an autonomous practitioner (Holden 1991, Gagnon et al., 2010, Skår, R 2010).<sup>55</sup> In so far as medical treatments go, other than her responsibility to ensure that her part in that treatment is competently executed, she is not autonomous with regard to choosing what that treatment will be. Indeed this lack of autonomy is highlighted when one considers the mass of nursing literature on her role as advocate. This and further exploration of the

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<sup>53</sup> See prologue.

<sup>54</sup> Where nurses do present themselves as healers this tends to be in the spiritual sense rather than curative. (Koerner 2011, Niven 2008)

<sup>55</sup> Indeed these papers tend to confuse responsibility with autonomy: the nurse can be responsible and have a sense of responsibility, but not necessarily be autonomous.

nurse's duty of care *versus* her right to conscientiously object will be returned to in chapter six.

## Conclusion

In this chapter I have argued that nurses have an erroneous conscience and in the case of conscientiously objecting to aggressive medical treatment they face three objections to the right to conscientious objection. Firstly, they do not have expert medical knowledge and therefore are at risk of being misinformed of the facts. Secondly they are in close proximity to the patient and tend to have an immediate and particular response to a single case that means that they can fail to have the consequentialist perspective and ethical reasoning that justifies such care. Thirdly they are psychologically primed to judge doctors' actions under such circumstances harshly, and even when faced with good outcomes, they are likely to overlook the original benign intention that drives many doctors' work. Fourthly, the nurse is obliged to follow contractual and public consensus with regard to her responsibilities, and these do not extend to making autonomous decisions about treatment, in the way that doctors do.

It seems that conscientious objection in the clinical arena is not supportable. However, again it seems pertinent to observe, that those nurses who choose to leave the profession or specialty due to their disagreement with aggressive medical care, may well express their conscience, as erroneous as it may or not be, in a supportable way because they do not impose their views on the patients



they care for, nor do they oppose the general consensus under which they are obliged to work.

## Chapter Five: *Medical legislation for conscientious objection.*

### Introduction

In this chapter a review of health care law and conscience will be made. Two major questions will be addressed. The first is to assess whether or not ‘futile’ care is deemed an act that is grave enough to deserve legal protection for nurses to conscientiously object to ‘futile’ orders. Secondly, the legal stance on the relationship between nursing and medicine will be considered. An underlying assumption is that law is an important source from which to find guidance, because it provides societal consensus; consensus having been identified as an important source for identifying moral truth. As shall be seen, the law does not offer support for Catlin’s position.

Legal sources will be taken from the UK and to a lesser degree, the United States. This is because there is little direct legal evidence in the form of cases for nursing in the UK.<sup>56</sup> Although US law serves to supplement the relatively few cases that specifically address conscience and the relationship of nursing to medicine, it should be noted that the differences between American and UK law in relation to conscience are significant and beyond the scope of this thesis, and therefore comparison between the two is necessarily limited. However, due to the lack of attention given to nursing in UK law, it is essential to seek some guidance from US law, to gain some impression of how UK law might view nurses and their

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<sup>56</sup> This has resulted from searches in Lexis and Westlaw and MEDLINE and CINAHL. In addition to this I discussed this issue with my colleague Manian (2011) a Senior Lecturer who specialises in nursing and medical law.

desire to conscientiously object to doctors' 'futile' orders. Given the greater autonomy of nursing in the US, it has been surmised that any American cases on this issue will tend to, if anything, reflect this autonomy or in other words be more liberal than the UK. It should also be noted that there are no cases that address nurses who have conscientiously objected to doctors' orders. Indeed nurses do not feature very highly in medical law and the cases brought to court. However, some cases will be presented that highlight the relationship of nursing to medicine; a key issue in whether or not nurses ought to be able to conscientiously object to doctor's orders. Finally, military law will be briefly re-examined, and again, support will not be found for Catlin's position.

#### Legal support for conscientious objection

That the sense of good conscience is a value worthy of preservation was founded as a principle, in 1948, by the *United Nations Declaration of Human Rights*. [1948]

It states that:

'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief.....in public or private, to manifest his religion or belief in teaching, practice, worship and observance. (Article 18)

This definition of conscience as a freedom of thought, religion and belief, was further developed by the *European Convention on Human Rights*, [1950-1966] where this is included. However, limitations to this right are specified:

‘Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or the protection of the rights and freedoms of others.’ (Article 9,2)

As can be seen, this article reflects the basis for much of the debate about conscientious objection in medical practice, where the rights of the professional to maintain a sense of good conscience are pitched against the rights of the patient to access controversial treatments such as abortion,<sup>57</sup> or indeed generally uncontroversial treatments such as blood transfusion<sup>58</sup>. In 2000 The *Human Rights Act* [1998] incorporated the *European Convention on Human Rights* and in article 9(1) the right to express freedom of thought, conscience and religion was legally embedded in English law.

So far, it seems that conscientious objection to aggressive medical treatment might be supported. After all freedom of conscience is a qualified right in law. However, the *Human Rights Act* has arisen from a long road of international collaboration, and although there is clear support for the expression of one’s conscience, it is important to contextualise this. Consideration for and protection

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<sup>57</sup> See for example, the winning essay for the American Medical Association by April (2009) where competing rights and potential for harm to patients is well presented and argued.

<sup>58</sup> This is discussed in the GMC document ‘Personal beliefs and medical practice: guidance for doctors.’ (2008)

of human rights has arisen from gross acts that have violated the dignity of the human person, such as torture, holding innocent people in police custody, acts of violence against women and unjustifiable killing. Such acts have been perpetrated by governments (or similar) (Clark, 2001). Although nurses and doctors are exposed to situations that can be extremely distressing and sometimes traumatic to observe, (Aase et al., 2008) under legal circumstances, they are not ordinarily the equivalent to these kinds of acts of intentional harm that have originally given rise to the *Human Rights Act*. However, since its inception the act has been applied to in circumstances that might be identified as fairly mundane<sup>59</sup> and has certainly offered guidance for medical care under difficult circumstances.

### The law

In chapter four I argued that conscience is a fourfold object and that the act that is associated with it is the most important feature. Medical law supports this position, because conscientious objection is only legally described in medicine for acts that involve killing or the manipulation of a human life in an artificial environment in the form of *in vitro* Fertilisation.<sup>60</sup>

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<sup>59</sup> See for example *R (Begum) v Head teacher and Governors of Denbigh High School*. [2006] where the right to wear religiously inspired dress at school was brought for defence.

<sup>60</sup> It should be noted that this process also requires killing of human life. Although at the cellular stage, this is deemed an atrocious act by some, and law severely restricts the age limit at which manipulation of embryos can be continued until, because of the ethical gravity associated with such work.

In the UK HCPs are given the right to conscientiously object to direct involvement in therapeutic abortion (*Abortion Act* [1967] and *Human Fertilisation and Embryology Act* [1990]). The *Abortion Act* states that health practitioners are not under any legal or contractual obligation to participate in abortions if they have a conscientious objection to doing so, although in any legal case, the burden of proof lies with the professional who has to prove that a conscientious objection exists (s.1(4)).

It seems perhaps, that medical law might provide a basis from which nurses could claim the right to conscientious objection to doctors' orders, given that conscience is respected in medical law. However, it should also be noted, that the right to conscientious objection in abortion is more restricted than it first might seem. The right is removed if the mother's life is endangered. Furthermore, although not generally acknowledged in debates or literature on this issue, it's interesting to note that this caveat is extended beyond saving the life of the mother to also saving her from grave physical or mental harm (s.4(2)). This extends the duty of the health care practitioner beyond being obliged to save a life. This means that the law tends to restrict rather than promote or support conscientious objection presumably because the duties of the HCP outweigh personal interest.

It is worth some examination of conscience and the law outside of medical law to support this position, because it demonstrates that even when negative consequences are associated with placing restriction on the expression of conscience, that restriction will tend to be exercised; that is article 9(1) is a

qualified right and can be infringed when ‘necessary and proportionate’. For example, in the Leeds based Catholic Adoption Agency wanted exemption from the *The Equality Act (Sexual Orientation) Regulations [2007]* on the basis of religious belief associated with homosexuality, and was prohibited from excluding same sex couples from the adoption process. Here the expression of a conscientious refusal was disallowed because of the legal position on discrimination against homosexuals (and the infringement of their rights) associated with such an act (Butt, 2011). Clearly, this decision could have associated with it the negative consequences of fewer adoptions.

Similar to this case, but in this instance under health care law, in *North Coast Womens’ Care Medical Group v Sandiego County Superior Court [2008]*, doctors in the US refused to artificially inseminate female couples on the grounds of religious belief that homosexuality and the promotion of life under this condition was wrong. Here the court found that doctors were not entitled to claim conscientious objection because to do so, was to harm by discrimination.<sup>61</sup>

Despite this restriction it could perhaps be argued that the nurse might have a right to conscientiously object to doctors’ ‘futile’ orders because she has a causal responsibility for treatment outcomes. The extent to which direct involvement is defined, was at least partially demarcated in the *Janaway vs. Salford HA [1989]*, where a Roman Catholic secretary in good conscience refused to write a letter of referral for patients intending to have an abortion. She was dismissed from her

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<sup>61</sup> *Janaway vs. Salford HA [1989]* is another example of the restriction of the right to conscientiously object in professional life.

post and was not able to defend her position in law, because the act of writing the letter was seen as an ancillary act that was not protected by s 4. In this instance the secretary's actions were found to be too remote from the patient and the act of abortion to justify her conscientious objection. This does demonstrate that the nurse is proximal to the patient and therefore any acts she is involved with are by law, acts for which she has responsibility. However, this does not equate with causal responsibility, or to put it differently, the responsibility that is attributed to the nurse in law is not equal to that of the responsibility of the doctor: the doctor carries causal responsibility and the nurse carries responsibility to carry out legal orders competently.

So far then, the support for Catlin's position appears to be weak, except that nurses do have causal responsibility for the results of their actions. As shall be seen though, this becomes even weaker when examination is made of how the law identifies the duties and obligations of the nurse and her responsibilities in relation to the doctor.

### Medical law and futility

Recourse to human rights and the *Human Rights Act* [1998] has been made in medical law and the determination of whether or not treatment is futile, for example, in *R v General Medical Council* [2004], a case brought by a man suffering a degenerative neurological condition that would eventually lead to loss of physical capacity to eat, drink and breathe independently. This case originally



determined that patients could require reasonable treatment, even if the doctor disagreed with it and in this case, it would be because the doctor identified the treatment to be futile. It was conceded that medical treatment could constitute a 'degrading' act, as is specified in Article 3 of the *Convention for the Protection of Human Rights and Fundamental Freedoms* [2010] and in this case, it was deemed that medical treatment could be considered degrading, if artificial nutrition and hydration were removed from a conscious patient who did not wish for this to occur (s.7) This case was later overruled in the court of appeal in *R v General Medical Council* [2005] on the grounds that artificial nutrition and hydration would not be removed under the conditions originally brought by *R*.<sup>62</sup> The court of appeal redressed the balance with regard to patient and doctor autonomy; that is that doctors are required to respect a patient's wishes for treatment, but that they are not obliged to give treatment under conditions that have become unequivocally futile. Nevertheless, the initial finding that medical treatment could be degrading is still of significance for this thesis because it indicates that nurses might identify degrading treatments in conditions of moral distress.

In contrast, the *Airedale NHS Trust v Bland* [1993] case also accessed the concept of human rights, where it was acknowledged that intensive treatment that prolonged life could be intrusive of privacy and human dignity. In this case Bland, a young patient in continuous vegetative state and on naso-gastric feeding was eventually allowed to die after withdrawal of that feeding. Interestingly in

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<sup>62</sup> That is the fear of the patient that doctors could decide to withdraw artificial hydration and nutrition under conditions where the patient was not yet facing imminent death and where the patient wished to continue this life preserving treatment.

this case degradation was not specified; perhaps ‘degradation’ is associated with the taking of life, rather than its preservation.<sup>63</sup>

A recent case *W v M* [2011] is also worth mentioning, because the preservation of life and artificial feeding and hydration was considered appropriate for a patient in persistent minimally conscious state, again taking lead from the *Human Rights Act*. Such cases as these, and the fact that courts are called on to make difficult decisions in end of life care, reflect the difficulties that nurses face in their practice.

*Airedale NHS Trust v Bland* and *W v M* are important cases because they both illustrate the certainty that has to be associated with the most difficult ‘futile’ medical cases that come to court. Medical treatment can be withdrawn when it is known to be futile as in *Airedale Trust v Bland*, but where there is any kind of hope, and in the case of *W v M*, this was hope of a very limited life, medical treatment is continued. Some support for my position is given by these cases because it seems that the law will err on the side of caution when identifying futility, and the preservation of life is its first objective. In other words, the nurse who wants to object to ‘futile’ treatment of a patient who just might survive does not seem to be supportable in law. As shall be seen, once the status of nurses in relation to medicine is examined, then there is little question of the societal consensus on Catlin’s position

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<sup>63</sup> This might also simply reflect that the *Human Rights Act* was not yet part of law.

## Medical law and the nurse

As discussed in chapter four, nurses have seen them selves as having been an oppressed group of women, under the authority of doctors who were largely men. It could be argued that this oppression is detrimental to the nurse, but also that the nurse is a voice for the patient who is being harmed by medical treatment.

There is no doubt that the nurse might be faced with a situation where she is required to protect the patient from professionally and legally recognisable harm, and indeed as shall be seen in the next chapter on professional codes, there is an obligation for nurses to act to protect patients, and themselves from abuse. <sup>64</sup> (NMC 2011) However, important in the question of whether or not conscientious objection ought to be supported for nurses who object to ‘futile’ orders is examination of where the nurse stands in relation to medicine. Nurses are educated to see themselves as autonomous practitioners, (Wade 1999) but in law, it is clear that the nurse’s professional role is limited and is largely defined by her relationship to medicine. Such limits and definition, as shall be seen, serves to support the position that for the nurse to conscientiously object to medical orders is not supportable in law unless those orders are illegal. This is for two reasons. Firstly, as has already been shown, where doctors decide to withdraw treatment, they do so under conditions of certainty, or at least

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<sup>64</sup> An example of such an action is described by Carmon and Tabak (1997) who wrote a paper in protest at immoral practices in Israeli medical practice, where patients were being allocated treatment on the basis of bribes and other fraudulent behaviours. Whistle blowers can also fall into this category (Alford, 2001).

certainty of a body of medical professionals, that the treatment is agreed by consensus to be futile, a circumstance that does not arise in instances of moral distress. Secondly, the nurse is not acknowledged as a professional with medical expertise equivalent to a doctor

This demarcation between responsibility and authority is demonstrated by the *Royal College of Nursing of UK v DHSS* [1981] where the Royal College of Nursing (RCN) declared that a circular that was sent out by the Department of Health and Social Security and that authorised nurses to administer prostaglandins to induce abortions was unlawful, because abortions could only be legally performed by doctors. The House of Lords held that so long as the nurse was acting on doctors' orders, then the nurse could carry out the prostaglandin administration. Here then, it becomes clear, that when acting on another's orders, the line between what one might feel personally and professionally responsible for and what one is judged to be responsible for is open to disagreement. As far as the law is concerned, the responsibility of the nurse is to carry out the procedure competently, but the responsibility and authority to decide to perform the act and the causal nature of the act, lies with another professional: the doctor. Where the nurse delivers drugs and treatment then, although she has responsibility and a causal relationship to events that occur; to the observer, she does not act with authority or 'total responsibility' for that action. This state of affairs perhaps reflects the military associations that Catlin made. The soldier carries out acts under the authority and direction of a senior officer or government.

This view is supported when one examines other cases that do not directly relate to conscientious objection. Firstly, the nurse does have authority as an advocate who is responsible for monitoring and detecting changes in a patient that indicate that a doctor's presence is necessary. This is seen in *Bolitho v City and Hackney Health Authority* [1997] where the doctor in charge of a young boy's medical care failed to attend the patient after receiving two phone calls from a senior nurse, who reported significant cardio-respiratory events. The failure of the doctor to attend the patient was found to be negligent on the basis that the medical information communicated by the nurse during two telephone calls, ought to have alerted the doctor to the necessity that she attend the patient. This case establishes the important role of the nurse in medical care. However, it is worth noting that the nurse's medical opinion was not sought and whether or not the nurse required the doctor's attendance does not seem to have been an issue. In other words, the nurse demonstrated competence in making the decision to bypass the house officer and to phone the senior doctor, as she decided to do when the patient's condition deteriorated. But she did not have authority in the eyes of the law, to require the doctor to attend the patient. Whether or not she asked the doctor to attend was not discussed in the case proceedings, and indeed the medical decision about whether or not the patient ought to have been intubated, did not include the clinical judgement of the nurse, but rather medical practitioners.

This tendency to overlook the nurse, or perhaps to state more correctly, to identify the nurse as working under the authority of the doctor, is further supported when one examines the case of *Airedale NHS Trust v Bland* [1993] In

this case, a young man, Tony Bland, was alive and under intensive nursing care and medical treatment but was suffering from persistent vegetative state. The case centred on the decision whether or not to withdraw artificial nutrition and hydration, and much of the judges' exploration centred on whether or not this was a medical treatment or provision of basic care. The judges were sympathetic to the position of nurses in the case, and indeed nurses were included as witnesses. However, it is difficult to distinguish what they contributed to the final decision, because only doctors and medical opinion was referred to in the presentation by each judge. Indeed, the judges persistently argued that there was no distinction between medical and nursing care. That is, nursing care was identified as a part of medical care.<sup>65</sup> Furthermore the weight of responsibility for the decision was firmly placed in the hands of the medical profession, with support from the legal profession. Lord Hoffman, in his statement, argued that the hospital and doctors are responsible for medical and nursing care of patients. Lord Mustill in his summing up made it clear that he appreciated that the withdrawal of artificial feeding was very difficult for nurses, but that he hoped that they would understand that the decision had been made in the best interests of the patient. Again, this statement makes clear that the nurse is not considered party to medical decision-making, even though her opinion and perspective is considered, it is not considered as a voice of authority in medical cases.

Goodman (2004) came to a similar conclusion in her analysis of the case of Ms B, a patient who requested withdrawal of ventilation after a spinal haemorrhage,

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<sup>65</sup> This contradicts the position that nursing is distinct from medicine and that it is autonomous.

noting that the perspective of nurses in the medical decision-making was absent, or at least not reported.

It is difficult to find medical cases in the UK that specifically address nursing negligence.<sup>66</sup> <sup>67</sup> Most cases and literature that exist are found in the US.<sup>68</sup> This might reflect the litigious nature of US society where nursing negligence leading to outcomes such as pressure ulcers are more commonly brought to court and damages sought whereas in England, people may be less likely to take such cases to court. Harris (2011) might support this claim, as he found that the number of legal claims for negligence brought against nursing homes in the US did not correlate with the level of care provided; that is those that provided good care were sued just as frequently as those with low level care. It might though, also result from the fact that cases of nursing negligence are less controversial because the issues such as negligent practice and causation are less open to debate, and therefore more readily settled outside of court.

A case from the US further supports this position because it demonstrates again, the position of nurses in relation to doctors. In *Broehm v Rochester* [2005] a patient brought to court a case of negligence after she had a complicated recovery from tracheal surgery. The surgeon in question had a method of restraining patients post surgery that led to the patient having a wound on her

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<sup>66</sup> More cases can be found for midwifery negligence such as *Marjory Campbell (A.P.) v Borders Health Board* [2011]

<sup>67</sup> Miola (2009) makes a review of cases relevant to nursing negligence, but again few cases specifically deal with nurses.

<sup>68</sup> See for example Pohlman (1989), Eisenberg (2010), Meehan et al. (2002), Lee (2000)

forehead that did not heal properly and left scarring. The case was initially dismissed because the expert witness brought by the plaintiff was a nurse practitioner: the court held that a nurse cannot provide expert witness for medical practice.

In contrast, the authority of the doctor over the nurse, even in relation to nursing care is demonstrated by Tammelleo (1994) who quotes the case of *Crook v. Funk* [1994] where a US court conceded that a doctor could act as expert witness in a case of nursing (not medical) negligence.

All these examples support the argument, that even though the nurse is responsible for delivering medical care under the authority of the doctor, and even though she is accountable for this practice, she is not considered qualified to make medical decisions, and of course, this includes the decision about whether or not a treatment is futile. It therefore is not supportable, from a legal perspective, for the nurse to conscientiously object to 'futile' medical orders, so long as the medical orders are legal, because she is a nurse. It is worth noting that conscientious objection to a doctor's orders for medical treatment is fundamentally a difference in medical opinion: the nurse believes the treatment to be futile and the doctor does not.

#### Military law and illegal orders

As has been highlighted, there is no case in UK law that addresses a nurse who refuses to carry out a doctors' orders and even though it is not supportable that



she could do this in relation to 'futile' orders, it is likely that she would be held accountable for following an illegal order.

Military law offers some evidence for this position. Takemura (2006) describes how international law does not give protection for soldiers to commit atrocity or other illegal acts of war and to seek defence in superior orders. Soldiers who are under authority and are expected to follow orders, are not expected to be obedient to those orders under any circumstance. If those orders contravene international law, there is an expectation that the soldier will not follow those orders. Should he commit an illegal act, he is not guaranteed to be free from punishment because he is under higher authority. Indeed illegal acts such as genocide or *apartheid* are considered to be acts that 'shock the conscience of mankind' (Takemura, 2010, p.216).<sup>69</sup>

This contradicts the perception of soldiers as being blindly obedient actors in a war. Catlin does not include this legal point in her analysis on conscientious objection and in so doing misses an important perspective: moral distress and medical orders that a nurse disagrees with are one thing, but moral outrage that results from illegal or professionally unacceptable behaviour is another. When a nurse observes a wrong-doing, either because it contravenes law or because it contravenes societal and professional obligations, the conscientious objection clause for morally distressed nurses could lead to the nurse's abdication of

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<sup>69</sup> Takemura also occasionally examines conscientious objection in law, for example in his discussion about whether or not soldiers ought to be able to conscientiously object to specific wars on the grounds of being illegal in international law. Recent cases were discussed in chapter three.

responsibility. This is because conscientious objection might disassociate one from actual wrong-doing, but it does not necessarily require a positive act to prevent actual harm.

In support of this position, Hardingham (2004) describes an incident that she experienced as a junior nurse that she identified as moral distress. Whilst working in the emergency room she observed a difficult patient who was bound, gagged and laughed at by co-workers, whilst they provided clinical care to the patient. In the paper she concentrates on the personal aspects of moral distress – the perception of wrong-doing, the emotional response to it and her inaction because of her sense of constraint, due to her relatively junior position. She did conscientiously object to involvement with the act, by removing herself from the situation and observing from a distance. At the same time she felt badly about not doing more. As far as Catlin is concerned, it seems that this would be enough. However, because the actual nature of wrong-doing is not properly articulated in moral distress, there is no distinction made about wrongs that ought to be tolerated and wrongs that ought not to be tolerated. The nurse, like the soldier, needs to distinguish between moral distress where she faces difficult situations that are morally uncertain and where she faces a situation where wrong is undoubtedly occurring. Returning to the significance of the act and its link with conscience, if an act steps outside of moral uncertainty, into moral wrong-doing, then although the nurse is justified in removing herself from performing that act, given her professional relationship to the patient, conscientious objection does not go far enough, and indeed, if conscientious objection is her only response, the nurse becomes complicit in allowing that wrong-doing to continue.

## Conclusion

The law is reticent in its support for conscientious objection, except when a person is required to kill. In this instance, the gravity of the act and presumably the harm to personal integrity that would result, is given priority. However, even so, this is still restricted as the instance of abortion demonstrates; the health of the mother will take priority, even though killing of an embryo or foetus is required to achieve this end.

The law concedes that medical care can be degrading and invasive of personal privacy. However, the preservation of life is a principle that takes priority. Even if the nurse perceives medical care to be degrading and futile, her role is one of advocacy and provision of nursing care. She does not have the authority to make medical decisions, and ultimately authority lies with the doctor. The authority of the doctor even takes precedence it seems, when it comes to the proper provision of nursing care, because in law this is seen to be a constituent of medical care.

## Chapter 6: Codes of conduct and conscientious objection.

### Introduction

In this chapter professional codes will be examined. A comparison will be made between the NMC code of conduct and other codes of conduct. Firstly the UK General Medical Council (GMC, 2006) code of practice will be examined, to make comparison between nurses' and doctors' professional guidance on conscientious objection in the UK; it seems reasonable that nurses in the UK could claim to have broadly similar conscientious objection rights to doctors. It also seems reasonable to conclude that the NMC ought to be similar to the GMC, because one would assume that UK nurses and doctors approach the ethics of personal and professional ethics similarly. Secondly, the UK Nursing and Midwifery Council code (NMC, 2008a) will be compared to the American Nurses' Association code (ANA, 2001) and the International Council of Nursing (ICN, 2006) code, to gain an impression of how UK nurses compare to those in an international arena. The prime purpose of this comparison though, is to identify the character of the NMC code in relation to conscience.

As shall be seen, if the NMC were to follow the example of the GMC and ANA, it could specify and develop the idea of conscience and conscientious objection for UK nurses. The question of whether or not the UK nurses' code of conduct ought to become more similar to their UK medical colleagues and US nursing colleagues will be addressed.

## Exclusion

Examination of pharmacists' codes have been excluded even though there have been contentious issues around dispensation of the contraceptive and morning after pill in recent times (Johnston, 2001; GPC, 2010). There are two reasons for this. Firstly the issues around conscientious objection in pharmacy practice specifically link to the abortion debate and interpretation of law around direct involvement with activities that could be associated with abortive practice. This is an area of exploration that lies outside of the parameters for investigation in this thesis. Secondly, pharmacists are qualitatively different than nurses and doctors. Their role with patients is less intimate, and they provide a specific scientific role over a short period of time without prolonged involvement with the patient and their role is less ambiguous than that of the nurse; the pharmacist has a clearly defined role and the lines of authority and responsibility are clearly delineated between the pharmacist and doctor.

It should be noted that this chapter does not aim to provide a critique of nursing or medical codes *per se*, there are many papers that provide detailed discussion on the strengths and weaknesses of such codes (Fullbrook, 2006; Kirkland, 2008; Gill & Griffin, 2010; Pattison & Wainwright, 2010). Instead it seeks to examine how conscience is framed in codes of conduct. However, with regard to the codes and conscientious objection there is little literature. A MEDLINE and CINAHL search only brought up one letter on the GMC and personal beliefs (Breen, 2008) and none for the NMC. Pattison & Wainwright point out in their paper on the new NMC code (NMC, 2008) that there is no mention of conscience or broad

ethical guidance on how practitioners are expected to reason in practice and this will be discussed in this chapter. One paper was found that called for nursing leaders to consider the organisational changes required to support conscientious objection as stipulated in the Canadian Nurses Association code which is broadly similar to the ANA code (Ford et al., 2010), but besides this, no critiques of the codes and conscientious objection *per se* were found.

### GMC code of conduct.

Catlin does not explore conscientious objection in the GMC medical code of conduct, (GMC, 2008) but had she done so, she might have found support for the inclusion of conscientious objection in nursing codes.<sup>70</sup> This is because the GMC medical code of conduct, when examined in the light of guidance on personal beliefs, gives a surprisingly broad support for doctors to conscientiously object to certain treatments.

In 2008 the GMC published guidance for doctors, on balancing their personal beliefs with medical practice. As would be expected, this guidance requires doctors to respect their patients' personal beliefs, and not to impose their own beliefs on them, nor to challenge these beliefs. It is stated that where a doctor has a personal issue with a form of treatment he is obliged to refer onto another doctor and to assist in this referral if the patient requires help (s.17-29). The

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<sup>70</sup> The advice in professional medical literature is variable. For example, the American College of Obstetricians and Gynaecologists' ethics committee frames conscientious objection as a right that ought to be strictly limited, presumably because of the controversial issues that have arisen from contraception, sterilisation and abortion in the US.

evidential support cited for this section is the *Abortion Act* (1967). However, later in the document, specific examples are given that lie outside of this Act. The guidance is it seems deliberately left rather open to interpretation about what procedures a doctor might conscientiously object to, but some explicit examples are given.

Firstly, male circumcision on religious or cultural grounds is specified. The doctor is referred to the conscientious objection procedure if he has an objection to circumcision other than in cases where clinical need is indicated. On the contrary, those doctors with a religious objection to cremation, are explicitly excluded from the right to conscientious objection to the filling in of cremation forms, because their refusal to do so could result in the remains of patients being sent to the coroner and an associated *post mortem*.

Presumably these examples are given because each demonstrates how personal values on the part of patient or doctor might be a source of conflict and perhaps the cases are designed to show when conscientious objection is most justifiable (in the case of circumcision) and not justifiable (cremation). In other words, the cases lead one to conclude that the doctor is not obliged to carry out clinical procedures that are requested on the basis of religious belief or cultural norms, but that likewise, the doctor's own religious beliefs are not allowed to extend so far as to cause serious psychological harm, nor to intrude on strongly held societal consensus about disposal of bodies. However, the code does state that just as the *Abortion Act* supports doctors to conscientiously object to direct involvement in abortion:

‘The same principle applies to the care of patients before or following any other procedure from which you have withdrawn because of your beliefs.’ (s.26)

Of significance is the fact that the GMC guidance explicitly offers doctors some protection to act or not act in accordance with their own personal values so long as they do not impose these values on their patients and offer referral to another doctor.

There is some confusion in the doctors’ code of practice. True the doctor is granted leeway to agree to perform or to refrain from performing specific clinical acts. However, the decision of whether or not to carry out a circumcision might be more correctly identified as a matter of clinical judgement; in deciding whether or not to carry out an invasive procedure, the doctor needs to decide whether or not the risks are worth the benefits of the procedure in question (Shaw, 2009). Should he disagree that a new born ought to receive a circumcision, with its inherent risks, on the basis of parental preferences, it seems reasonable to allow the doctor to refuse to carry out the procedure, as any negative consequences will be directly his own responsibility and any blame associated with it.<sup>71</sup> Furthermore, his patient is unable to consent. This then is not really a matter of conscience, but one of an assessment of professional values and calculations around consent and risk.

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<sup>71</sup> There are conflicting sources of evidence on the risks and benefits of non-therapeutic infant circumcision. See for example Sanson et al. (2010) Conroy, (2011) Dettmeyer et al. (2011).



Here doctors have an advantage over nurses, because their clinical decisions and acts fall under their own realm of responsibility and authority. The nurse has the same autonomy with regard to purely nursing actions,<sup>72</sup> but unlike the doctor, she is obliged to carry out actions that are outside of her own clinical authority.

The GMC does not give detailed information about the kind of issues that might arise within the breadth of situations where conscientious objection is possible, but the Canadian Nurses' Association (CNA, 2008), which is similarly liberal does specify blood transfusion and this could presumably also be included, given its strong link with Jehova's Witnesses, although it is most commonly discussed in relation to non consenting patients, rather than HCPs who are Jehova's Witnesses (Banja 2009; Doyle, 2002). Perhaps blood transfusion and transplant opposed to on the grounds of conscience offer insight into the broader range of procedures the doctor might wish to make a conscientious objection to.

In this instance it is a conscientious objection in the true sense of the word, because it arises from deeply held personal and religious belief. Perhaps the GMC does not list such matters explicitly, because it does not wish to encourage conscientious objection on these grounds, but also because bringing such issues to light in the public realm could cause outrage. There is no doubt that conscientious objection for these reasons would be contentious, but presumably, the code, like the *Abortion Act*, would expect doctors to carry out treatments to

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<sup>72</sup> Although as was discussed in chapter five, legally she might not.

which they have a conscientious objection should no one else be available, or if patients are put in danger.<sup>73</sup>

Despite the differing views in ethical analyses about whether or not doctors ought to be able to conscientiously object to treatments that conflict with personal values<sup>74</sup>, it is clear that the GMC offers significant leeway for conscientious objection; a freedom to express personal autonomy that is distinctly absent in medical law, with regard to conscience at least. The assessment of the gravity of the nature of the act –which I have argued is the most important question to answer in professional and societal cases of conscientious objection - is absent from the professional body's perspective; that is, the right to conscientious objection is not limited to grave acts that involve killing.

#### NMC, ANA and ICN codes

The Nursing and Midwifery Council Code of Conduct (NMC, 2008a) makes no reference to conscience or conscientious objection. Nor does it make reference to the nurse's personal beliefs or values. Unlike the GMC and as shall be seen, the ANA, there is no equivalent document that advises or gives leeway for nurses to make decisions to act or not act in relation to their own personal values other

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<sup>73</sup> Wicclair (2011, pp87-134) gives a good review of the reasons that limit conscientious objection for HCPs.

<sup>74</sup> There are numerous papers on conscientious objection in medicine that give the standard arguments that support it or not. Wicclair (2011) gives a good review of the ethical issues, but see also Wicclair (2000) Saulescu (2006) Dickens (2009) Gillon (1985) Gronlund et al. (2011) April (2009)

than to reiterate the legal boundaries of conscientious objection as specified in the 1967 *Abortion Act* (NMC, 2008b).

However, there is advice on duty of care, which gives explicit circumstances where the nurse might be justified in withdrawing her care. The NMC guidance states that the nurse can withdraw her care only when she fears physical violence, where there are environmental health and safety hazards, or where the nurse is experiencing sexual or racial harassment (NMC, 2008c). Such instances are not described as a matter of conscience presumably because the decision to withdraw is one of preserving physical safety, rather than the more esoteric preservation of a sense of integrity that exists when one withdraws for moral reasons. What is striking about these examples is that although the NMC does not speak of conscientious objection, other than in relation to abortion law; by giving examples of when the nurse can withdraw care, the withdrawal of care on the basis of conscience is clearly omitted.

Further to this, there is only a short mention of integrity in the code of conduct where it is framed in relation to issues such as being law abiding and having a commitment to diversity and equality (p7). As was the case with the reasons for withdrawal of care, these are generally accepted norms that do not express the individuality promoted by the concept of conscience. No reference is made to integrity in the 'higher order' sense of congruence between personal and professional values and actions.

The International Council for code of ethics (ICN, 2006) is intended for all nurses as a guide to excellent practice and gives a global framework for nursing practice. Like the NMC code, no mention of conscience or conscientious objection is made in the code, or elsewhere in their guidance literature, although in it, there is reference made to harm being done to patients by other health care practitioners. Practitioners and managers are required to 'Develop mechanisms to safeguard the individual, family or community when their care is endangered by health care personnel' whilst educators are required to instill this value in learners, and nursing associations are required to develop guidelines and position statements with regard to dealing with such situations (p.8). No mention is made of the behaviours expected from nurses in relation to such circumstances, but the word 'endangered' implies intentionally harmful behaviours rather than disagreement about treatment options as occur in moral distress.

Guidance is not specified in the NMC code and so far, the NMC has responded reactively to the issue of safeguarding patients, with guidance on these matters having been formalised after a Panorama BBC documentary that resulted in a nurse being struck off the register for undercover non consensual filming (BBC 2009; Cunningham, 2008). The nurse in question filmed patients in the Royal Sussex Hospital because she observed that care standards were below acceptable limits, and she wanted to prevent such circumstances from continuing, and became a 'whistle blower.' The guidance provided to nurses in 'Raising and Escalating Concerns: Guidance for Nurses and Midwives' (NMC

2010) has set out clear instructions about how professionals ought to react to circumstances where patients under their care are exposed to:

‘abuse, which is defined as “a violation of an individual’s human and civil rights by any other person or persons” (No Secrets (2000) Department of Health). Abuse may occur as the result of deliberate intent, negligence or ignorance, and includes (but is not limited to) physical, psychological or sexual abuse; financial or material abuse; neglect and acts of omission or institutional abuse.’ (p. 2)

Of interest in this document is that ‘doing nothing and failing to report concerns is not acceptable’ (p. 4). This supports the stance that conscientious objection could actually be an abdication of responsibility for the vulnerable patient. Indeed, this clause was added to the guidance document after a focus group consultation in early 2010 (NMC, 2010b) led to the conclusion that non action was not an ethical option under such circumstances. Furthermore, contrary to Catlin’s proposal that conscientious objection could only be enacted after a prolonged time where the position of the nurse had not changed, the UK guidelines, stipulate that under some circumstances immediate action needs to be taken in order to cease incidents of unsafe or unacceptable care. Within the guidance ‘Safeguarding update’, (NMC, 2011b) the NMC makes it clear that abuse of patients could be at the hands of doctors who prescribe inappropriate treatment, but again, under such circumstances, it is clear that the nurse is

expected to act, and this action is not one of conscientious objection, presumably because prevention of abuse requires the nurse to act as the patient's advocate.

It should be noted that these circumstances – those stipulated by both the ICN and NMC - are more akin to the analysis I made in the previous chapter where I argued that in instances of definite wrong-doing, that is incidents that more correctly apply to a sense of moral outrage than moral distress, ought to be responded to in a strong and definite manner that goes beyond conscientious objection. Indeed, Catlin's proposal that the code of conduct contain a conscientious objection clause in relation to over treatment of patients does nothing to safeguard patients who might indeed benefit from less treatment. However Birchley's (2011) suggestion that conscientious objection ought to be institutionally recognised with the opportunity for HCPs to attend a formal setting such as a tribunal to express concerns, could offer protection to patients because conscientious objection under these conditions becomes an action with transparent and accountable actions associated with it.

Interestingly the ANA code is more similar to the GMC code than to the NMC or ICN code. This might reflect the historical development of nursing in the US, which has, as has already been discussed, followed a strongly feminist interpretation of nursing and its relationship to medicine. It is a far more detailed document than either the NMC or ICN codes. The ANA states that the nurse's prime responsibility is to the individual patient, and that the patient's interests take priority over other health professionals or members of that patient's family (Provision 2.1 and 2.1). Although the NMC code also has the

individual patient as its prime concern, it is not so explicitly stated in relation to potential contenders for this focus of nursing activity, stating only that:

‘You must treat people as individuals and respect their dignity’

The more detailed ANA code perhaps reflects the large body of seminal work done in the US where the role of nurse as patient advocate was first theorised<sup>75</sup>. Interestingly, the nurse advocate is seen to be the professional who takes the side of the patient in opposition to other HCPs, and particularly the doctor (McGrath and Phillips, 2009; Hanks, 2010; Martin, 1998a & 1998b; Kendrick, 1994).<sup>76</sup>

The NMC code emphasises working co-operatively with other team members including the statement:

‘You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues’ (point 24)

The ANA has a much longer statement that seems to reflect an adversarial sense of relationship that I have alluded to above. Rather than stating that the nurse

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<sup>75</sup> Mallik (1997) offers a good review of theoretical approaches to advocacy in nursing.

<sup>76</sup> The adversarial nature that can be associated with the ANA code isn’t limited to the doctor, but can also be associated with other powerful influences such as racism (Harrison and Falco, 2005). Of interest here is that the doctor is identified as potentially as wrong as the person who is racist.

ought to work co operatively with other HCPs, the ANA sets down the form of communication that ought be present in multidisciplinary care, and although it isn't stated as such, it seems to be more of a statement about how the nurse ought to be communicated with, than how she ought to communicate. After stating that health care is a multidisciplinary activity, the code states:

'Within this context, nursing's unique contribution.....and relationship with other professionals needs to be clearly articulated, represented and preserved. By very definition collaboration requires mutual trust, recognition and respect among the health care team, shared decision-making about patient care and open dialogue among all parties who have an interest in and concern for health outcomes.' (2.3)

Conflicts of interest are also identified as subject to the code and are best described by quoting another section of the code:

'Nurses are frequently put in situations of conflict arising from competing loyalties in the workplace, including situations of conflicting expectations of patients, families, physicians, colleagues, and in many cases health care organisations and health plans. Nurses must examine the conflicts arising between their own personal and professional values the values and interests of others who are also responsible for patient care and health care decisions as well as those of patients.



Nurses strive to resolve such conflicts in ways that ensure patient safety, guard the patient's best interests and preserve the professional integrity of the nurse.' (2.2)

Like the NMC, the ANA has guidance about reporting and escalating concerns, although in this instance it is termed 'addressing impaired practice' (3.6) and is contained within the code itself, rather than in an extra document as is the case for the NMC. The need for formal procedures for raising concerns are stipulated and again are similar to the NMC. With regard to safeguarding and impaired practice I am in agreement with the nursing codes described. The requirement for the nurse to act is clearly described as an essential element of nursing responsibility. These situations are clearly examples of wrong-doing that lie outside of the uncertainties and conflicting perspectives associated with moral distress in 'futile' care.

The ANA though, unlike the NMC and ICN but similarly to the GMC, has a section that addresses the personal and professional integrity of the nurse (Provision 5). Nurses are required to have 'moral self respect', and to maintain 'wholeness of character and personal integrity'. The code states that nurses merge both personal and professional values whilst becoming a professional and that these two can't be separated. The nurse has a duty to express her moral concerns even when they differ to those around her. The preservation of integrity is described as a primarily 'self-concern' of the individual nurse. Specific threats to integrity are listed such as receiving abuse from patients or co-workers, or being asked to behave in a way that is a direct contradiction of the code of ethics or legality.

So far this does not differ substantially from the NMC code, although the terminology is very different. However, nurses are required to preserve their sense of both personal and professional integrity, and to engage in 'integrity preserving compromise only to the degree that it remains an integrity preserving compromise' (5.4) Nurses who are in situations

'Where a particular treatment, intervention or activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardise both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Conscientious objection may not insulate the nurse from formal and informal penalty.' (5.4)

This statement involves some broad use of language that gives the nurse leeway for conscientious objection in a way that is not permitted in the NMC or ICN codes; they limit self-preservation or patient preservation to acts of actual harm such as abuse, or illegal practice. Of particular breadth is the statement that a treatment that is 'intrinsically' objectionable to the nurse can be objected to. Similarly to the legal case of abortion, but dissimilar to the case of conscientious objection to war, the statement ends with the requirement that the nurse is obliged to provide for patient safety and to ensure alternative sources of nursing care are provided for the patient and to avoid patient abandonment under such circumstances.

Although there is not a specific mention of moral distress and the harm of ‘futile’ treatment within the code as Catlin argues ought to be done, it seems that there is already scope for nurses to do as Catlin suggests. In other words, the nurse who feels that to treat a patient aggressively rather than palliatively is wrong, can already conscientiously object on the grounds of an intrinsic sense that that act is morally objectionable or because it is inappropriate for the specific patient.

However, perhaps it is more correct, in the case of disagreement with the doctor’s plan of care, to describe this issue as one of the nurse’s clinical judgement rather than conscience, similarly to the argument made for male circumcision. If this is accepted, then it leads to the question of whether or not nurses ought to be given leeway to object to involvement in care of a patient, not on the basis of conscience, but rather, because of clinical disagreement. In other words, where the doctor decides that he does not wish to carry out a circumcision on the basis of professional judgments about consent and risk, perhaps equally so, the nurse ought to be able to make her own professional judgments about suffering and the personal risk she is willing to take in relation to living with the self blame that she will experience after negative consequences in her patient’s journey. However, the chapters on law and the nurse and erroneous conscience, would solidly refute the position that the nurse ought to be able to make this objection, under legal orders. Furthermore perhaps Olsen’s (2007) position as argued in his editorial on conscientious objection, ought to be remembered, that is that nurses should have the vision to avoid working to the lower standard of duty that the doctor employs when he objects to medical provision.

So far then, there is at least some support for Catlin's position. Firstly the ANA code of conduct actively supports conscientious objection, and although objection to aggressive medical treatment is not specified, there is no obvious reason to exclude it; it is either already a component of the code or else should it be deemed appropriate to make it a special case, it could be specified as such. Secondly the UK code could be redesigned to be more similar to the GMC code and ANA code of conduct, if a movement towards conscientious objection is accepted to be a positive change, although problems with this approach have already been identified. In any case, if conscientious objection to 'futile' orders is to be accepted, it is important to identify who benefits from this change. After all, the NMC purports that its role is to 'safeguard the health and well being of the public' (NMC, 2011a). In the next section the arguments that object to this position will be presented.

#### Opposition to the inclusion of conscientious objection in the NMC code.

It is interesting to note that the UK code of conduct for nurses is primarily constructed with the aim of safeguarding patients and ensuring that nurses behave legally, whereas the directions in provision 5 of the ANA code make the nurse's sense of integrity the focus of concern. In this sense, the ANA code is very much one that takes the concept of conscience as its prime focus. Conscience and conscientious objection, is primarily a self-concern. Given that the nurse is a professional who has the care of patients as her first focus, one must question under what circumstances it is right for her to withdraw from the patient. This is

particularly important for nurses, perhaps more than for other HCPs, because proximity to the patient is a defining feature of what it is to nurse and be nursed (Schluter et al., 2010; Boyd and Munhall 1989; Giger & Davidhizar, 1990). Proximity is essential to the role of advocacy and the role of caring. (Gustafsson et al., 2009; Brown, 2011; Thomas, 2011) Indeed, the loss of proximity to the patient that has become an increasing trend in nursing, may well be a key factor in the recent attention given to poor NHS nursing care in the British press (Beckford, 2011; Martin, 2010; Smith, 2009) and earlier concerns raised by the Patient's Association about poor standards of basic nursing (Patients Association, 2009).

Although Catlin states that the nurse must not abandon her patient if she disagrees with aggressive medical care, this fails to recognise the importance of the unique nurse–patient relationship that is so connected to proximity. Vouzavali et al. (2011) carried out a study on critical care nurses to find out how this relationship could exist with patients who are critically ill and unconscious. They found that the nurses had a deep sense of relationship with their patients through the repeated close contact with and care of their patient's bodies. This close contact evoked strong feelings of love empathy and care. Indeed, this experience was described by nurses as being mutually dependent.<sup>77</sup> <sup>78</sup>

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<sup>77</sup> An interesting connection might be found in this reliance on close proximity to the patient. As nurses have been increasingly removed from direct care activities for their patients, the feelings of love, empathy and care that are so essential to good nursing might well be diminished and contribute to poor nursing standards in hospitals.

<sup>78</sup> Metcalf (2009) provides an insightful analysis of Michael Ondaatje's 'English Patient'; one of the few novels to explore the nurse patient relationship in depth

Halldorsdottir (2008) highlights the importance of the nurse being with the patient and reminds the reader of the impact that relationship can have on improving a person's immune function and the detrimental effects of negative emotion on physical health. He argues that the nurse-patient relationship, that he sees as a primarily spiritual connection, is essential to good nursing, so long as the nurse is also competent, having professional wisdom and is genuinely caring. He found that the excellent nurse is described by patients as 'life giving'. (p651)

Given the essential nature of the close physical and emotional relationship that exists in excellent nursing care, it is important to identify exactly when the nurse is justified in breaking this bond; conscientious objection, will under many, if not all circumstances, break this bond. This will be examined in two stages. Firstly consideration will be given to conscientious objection understood as a disagreement in clinical treatment. Secondly, consideration will be given to conscientious objection in the truer sense of the word. These are two different lenses that will be used to gain a full perspective on the single proposition that Catlin makes, that is that conscientious objection to aggressive medical care that is active rather than palliative in nature.

### The Nature of Conscientious Objection to Doctors' Orders

Wicclair (2011) argues that conscientious objection in its truest sense, connects with deeply held personal values and not professional values. He argues that it is

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and echoing the sensual, compassionate nature of excellent nursing as it is described by empirical researchers.

incorrect to consider professional values as a source for conscientious objection. Although he has a philosophical point, this does not take into account the nature of the experience of professional practice and authors such as Koehn (1998, p11) argue that the division of personal and public that is commonly made in philosophical writing is psychologically and 'morally suspect'.

That this distinction is not necessarily correct is further evidenced when one remembers how nurses describe their experience of moral distress, where they perceive that they flog or torture a patient. Under such circumstances, were they identified as objectively (although not literally) true, then conscientious objection might be justified. Clearly there is an overlap between the professional circumstance the nurse finds herself in and the personal and grave nature of the act she perceives herself to be involved in.

One need only consider how nurses describe the nature of their relationship to the patient – caring, compassionate, loving – to see that the professional values that nurses hold may well be congruent with their personal values. Indeed much of what drives a person to become a nurse may in fact be an expression of those personal values. Support for this stance can be found from Michal-Rasin (2008 and 2010) who carried out empirical research to find what personal and professional values were carried by nurses and student nurses, (respective dates) both of these having been identified as important for well motivated nursing practice. So then, although distinction might be made between professional and personal values, and this might undermine Catlin's position

because conscience is an expression of deeply held personal values, I will not take this as an acceptable argument because of the reasons given above.

In conclusion this means that although there is a difference between objection to circumcision or objection to a doctor's plan of care and objection to abortion or blood transfusion: the first is a professional or clinical objection and the second is an objection based on religious grounds, it is defensible to accept them both as examples of 'conscientious objection'. However, it would be more correct to describe Catlin's position as one 'professional objection' or 'clinical objection'. This form of objection could be seen to be a subcategory of 'conscientious objection', and has specific issues associated with it, that do not necessarily overlap with 'personal conscientious objection', in its narrower sense. The idea that what Catlin describes as conscientious objection, is rather a clinical objection, brings into sharp focus the power difference that exists between nurses and doctors, that is so influential on the experience of moral distress. Added to this, although what Catlin proposes is really a professional objection, one must not fail to recognise the difficulty of continuing to care for a patient when one is emotionally disturbed, having the sense that the actions one does, are more akin to torture than care. Under these circumstances, the nurse who stays with her patient can hardly be a 'life giving' (Halldorsdottir, 2008, p650) source where a sense of spiritual connection can be maintained. But worse than this is to conscientiously object and step away from the patient and sever that relationship.



In chapter seven, exploration will be made into how the nurse can be cared for in such a way that her moral distress is lessened or removed, but for now, it is difficult to see how conscientiously objecting to doctors' 'futile' orders can be justified once the arguments in previous chapters are added to the detrimental effect on the patient should the nurse withdraw her care. The nurse is often working with limited empirical information, in law and in institutional constructs she is identified as a professional who is accountable and responsible for her practice, but in the medical sphere she works under the authority of the doctor. Finally, although Catlin states that the nurse who conscientiously objects must not abandon her patient, given the intimate nature of the nurse-patient relationship, this is exactly what she does when she seeks to pass on care to someone else. The patient will still receive the medical care he has been prescribed, and assuming that this is legal treatment, there is no resultant benefit to the patient.

Added to this is the worrying self-interest that is a fundamental feature of conscientious objection, after all codes already have in place guidance on frank abuse of patients, which may well include abuse by the doctor. The NMC code currently has the patient as its primary focus, but the ANA has a definite flavour of professional self-interest. As has been already noted, to specifically articulate conscientious objection to carrying out a doctor's orders as proposed by Catlin, reflects a fundamentally adversarial relationship between the nurse and doctor: the nurse conscientiously objects to the doctor's orders, and it is him with whom the conflict exists. Furthermore, it seems that this act does not only affect a preservation of integrity but is also an assertion of autonomy or power that the

nurse makes in relation to the doctor. Indeed Abbott (1988) describes the fact that nurses can be seen to be accountable to doctors for the medical treatments they perform as being intricately linked with 'professional power, jurisdiction and subordination' (1988, p.73) and as McGann (2004) has pointed out, the development of the nursing profession was a time of professionalisation for women everywhere after the growth of the women's movement in the US and the suffrage campaign in Britain. There is a danger that conscientious objection to doctors' orders could in fact be more about releasing nurses from this perceived subordination to doctors than about improving patients' lives.

The perception of professional inequality is certainly an erroneous source from which to justify conscientious objection. Firstly, it wrongly includes and affects the patient. Should there be battles to be made about this inequality, then nurses ought to ensure that the close bond that exists between nurse and patient in excellent care is not compromised. Such battles should be made away from the bed-side.

However, secondly, it is a misunderstanding of the relationship between nurse and doctor. To place conscientious objection under Catlin's position in the professional code of conduct, brings with it an associated responsibility or professional duty; that is the responsibility of medical decision-making. This effectively confers onto the nurse, responsibility for something for which in fact, she does not have responsibility. To imply to nurses that medical decisions are something for which they are responsible means that medical decisions might become too much of a focus for the nurse. Although nurses do have to consider,

evaluate and advocate for patients in response to medical decisions, the prime focus ought always to be nursing the patient. The promotion of the nurse as an 'autonomous practitioner' since the 1970s, that can perhaps have associated with it an inflated sense of responsibility, could well be a contributory factor to the experience of moral distress. Despite what nurses think of themselves, if they expect to have the authority to make medical decisions, they will inevitably be frustrated.

### Conclusion

In the preceding two chapters and this chapter, I have argued that conscientious objection to doctors' orders as defined by Catlin ought not to be included in the UK code of conduct despite its inclusion in the GMC code and the ANA code. Firstly, for the nurse to conscientiously object to doctors' 'futile' orders can be understood to be a clinical objection, and nurses do not carry authority to make this objection. As well, for the nurse to remain with the patient is the primary goal of nursing. Proximity is essential to the nurse emotionally responding to the patient and sustaining that patient physically, psychologically and spiritually through poor health. Doctors do not share this professional goal and the ANA code undermines the patient as focus because it gives too much priority to the self-interest of the individual nurse or nursing profession.

Chapter Seven: *Defence of the position that conscientious objection is unsupportable in 'futile' orders and alternative resolutions.*

Introduction

At the beginning of this thesis, moral distress was accepted to be a valid nursing experience, especially when caring for very ill patients who are likely to die and who are given 'futile' medical treatment. Emotions were accepted to be valid sources of emotional judgment so long as they withstood reasoned analysis. Conscience was accepted as being closely associated with moral distress and conscientious objection to doctors' orders in 'futile' circumstances was accepted as a reasonable response to moral distress and worthy of examination. However, reasoned analysis did not support the proposition that the nursing code of conduct ought to be altered so that conscientious objection to doctors' orders be included, as per Catlin's suggestion.

This chapter seeks to achieve two aims. Firstly, there is a serious objection to the position presented in this thesis. That is that nurses who do not have the right to conscientious objection under Catlin's conditions, might lose a sense of autonomy and responsibility for their actions. Such a loss could reduce the nurse to a professional who thoughtlessly follows orders. At its worst this could mean that nurses engage in harm to patients; harm that could be as bad as atrocity.

Secondly, an analysis of literature in the ethics of care and spirituality will be made in order to offer some resolutions to moral distress that add to the

literature that already exists on this topic. These resolutions will concentrate on ethical reasoning more than the practical application of these reasons. This is in keeping with Solomon's (2003) model of emotional judgement that requires reason to supplement emotion. In order to reach this end, the nature of harm that consistently appears in moral distress and that has been consistently identified through the reasoned analysis in this thesis, and that requires resolution will be identified.

### Lack of a right to conscientious objection might undermine conscience

It could be argued that if nurses are not offered the right to conscientious objection as proposed by Catlin, they might not have a sense of autonomy and responsibility for their actions. Should this claim stand up to analysis, it would effectively disassemble my position. This is because it would remove a sense of good conscience from the nurse; conscience having been accepted as an important feature of human and professional morality.<sup>79</sup> It would undermine the fourfold object that was identified to make up conscience<sup>80</sup>. Firstly, the sense of responsibility that is an essential feature of individual nursing practice (and nursing as a professional body) would be lost because nurses could be forced to detach themselves from a sense of responsibility for their actions.<sup>81</sup> Secondly, associated with the loss of responsibility, would be the loss of autonomy that has been so valued as nursing has moved from a 'subservient' past.<sup>82</sup> Thirdly, and

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<sup>79</sup> Chapter two.

<sup>80</sup> *Ibid*

<sup>81</sup> See p100-102.

<sup>82</sup> *Ibid*

most worryingly, this could mean that primary harm might be caused to patients. These wrong actions could be as wrongful as the committing of atrocity, as has already happened in Nazi Germany. Finally, and more nebulously, nurses could lose a sense of meaning and purpose that is essential to the work of caring (Meiers & Brauer, 2008; Gustafsson 2009).

All of these factors could reduce the quality of care of patients, but the latter two effects are the most important. That is, patients need to be protected and cared for and nurses need to be able to care. Although these are mutually interdependent states, it is essential that nursing does not lose sight of the fact that patients ought always to be the focus of our professional concerns.

Nurses who carry out actions that they believe to be wrong will thereafter lose a sense of responsibility, with a risk that they might subsequently carry out atrocities or wrongful acts.

Articles were written about the nurse as ‘technician’ in earlier decades, and the nurse as ‘technician’ is still a derogatory term when referred to in nursing circles. When used in a perjorative sense, it describes a nurse who is a professional with technical expertise who carries out actions obediently without consideration of a broader personal, ethical and clinical perspective; the task or the machine is the focus of activity, not the patient (Pickles, 1999; Parlapiano, 1972). When the ideas put forward in this thesis were suggested at the meeting on moral distress and conscientious objection (Yale University, 2009) many of the attendees used this term in response. To exclude conscientious objection

from the nurses' repertoire of potential responses to moral distress, was seen to reduce her to 'merely a technician'. Subsequent discussion was a little more tortuous both in its trajectory and in its final destination, but led to the conclusion that surely once one abdicates oneself from a sense of responsibility for one's actions, there is a risk that at some point one could be complicit in atrocious acts, such as those who participated and supported Nazi atrocities in World War One.

#### The evidence for irresponsible care leading to atrocity.

In the history of nursing, authors have highlighted the tendency of nurses in the past to be blindly obedient to doctors. Often negative associations are made between nurses of the past and such feminine qualities as submissiveness, powerlessness and so on.<sup>83</sup>

Reich (2001) discusses how nurses in Nazi Germany gave lethal injections to patients whilst encouraging them to receive the 'treatment'. This included participation in the killing of over five thousand disabled German children and seventy thousand handicapped adults (Benedict and Kuhla, 1999). He points out that under Nazism there was a manipulation of the concept of care, where care of the individual was usurped by 'care' of the whole society.

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<sup>83</sup> Rafferty et al. (1997, for example pp 23-24, p101) and Rafferty (1996) offer a substantial nursing history, with description of the feminist stance and fight against subservience to medicine frequently referred to.

Steppe (1997a, 1997b, 1997c) in her investigation into the reasons why nurses committed these acts, frames the complicity of nurses with Nazi atrocity and prejudice very much in line with the obedient/self sacrificing ideology of nursing at the time. It is interesting to note that some carried out their orders with what could be seen as a high degree of professionalism and empathic care. For example one nurse stated that

‘Patients who were strong enough sat themselves up in bed; we laid an extra pillow under the heads of the others in order to lift them up a little. In giving them the dissolved substance, I proceeded with great compassion. I had told the patients earlier that they had to have a little treatment. Obviously, I could only tell this little tale to those patients who were conscious enough to understand. In giving them the drink, I took them in my arms and caressed them. If they did not empty the glass, for example, because it tasted so bitter, then I encouraged them by saying they had drunk so much of it, they should drink the rest of it, because otherwise the treatment would not be complete. Some of them were so persuaded by my encouragement that they finished the glass completely. With others, we fed them by spoonfuls. As I said before, the way we proceeded was determined by the patient’s behaviour and condition.’(p21)



Some other nurses made the decision to carry out these orders because they believed in the underlying political cause. Steppe ends (p25) her analysis by questioning whether it would be good to question worldwide 'the degree to which obedience and adaptation are still characteristic of good nursing and how far we have really come with our demands for professional independence and self determination'.

Other researchers support Steppe's position. For example, McFarland-Icke (1999) found that nurses disassociated themselves from a sense of responsibility for their actions by relying on the authority of the doctor to excuse complicity in atrocities. Bauman (1993) has also described how a lack of responsibility can lead to always assuming someone else is responsible. Such a sense leads to complicity in wrong-doing such as nurses helping to transport patients to execution, whilst feeling no responsibility for the outcome. Staub (2003) in her work on bystanders who watched atrocities such as the Rwandan massacres has also discovered this lack of sense of responsibility.

The question of whether or not conscientious objection to a doctor's orders increases the nurse's sense of responsibility and therefore might protect patients from future wrongs such as those incurred in Nazi Germany, must be asked.

The reasons why conscientious objection does not reduce the risk of atrocities being committed by nurses.

Nursing historians such as Steppe have sought to understand nursing atrocities under the paradigm of feminist interpretation of the history of nursing. Such an interpretation has a narrow perspective that seeks to reconfirm prejudgments such as that nurses were subservient. It could be argued that such an approach has a self-serving interest; that is to further promote nurse autonomy and independence from medicine. This fight for independence from medicine can almost become the identifying feature of nursing history. Perhaps this reflects the difficulty in defining nursing as a professional activity. This is evidenced by many scholarly works<sup>84</sup> that seek to define nursing and establish a discipline of scholarly work which is nursing and nothing else, but that never seem to achieve this goal (Milton, 2008). Such a negative view of nursing history is no doubt detrimental to nursing. For example Ferrell and Coyle (2008) in their work into suffering and palliative care began their book by expressing surprise that much of what makes for good palliative care was found in nursing texts from the 1900s. Indeed, a strong sense of vocation and appreciation for one's professional traditions has been shown to be a feature of exceptionally creative people who are excellent examples of their field of work (Csikszentmihalyi and Nakamura, 2007). Sadly, nursing history seems to fail to offer a tradition that we can be proud of and in a culturally updated form, emulate.

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<sup>84</sup> These were discussed in chapter six.

This narrow interpretation of nursing history, leads to poor evaluation of wider causes of events such as the atrocities committed under Nazism. Although nurses might have used a sense of lack of responsibility for their actions to justify wrong-doing, there were other features that allowed them to behave as they did. After all, it wasn't just nurses who were complicit in such acts. Doctors were also complicit and can't be considered as obedient and self sacrificing in the same way – they weren't taking direct orders from a nurse, and the self sacrificing virtue is not one associated with men and doctors. Furthermore offenders included other professional groups, workers and society in general.

Essential to this event was the deep rooted and widespread anti-Semitism (Goldhagan, 1996). Indeed, it was not so much the lack of a sense of responsibility that allowed these events to happen, but rather the elimination of a sense of conscience, or 'overlain conscience', as has been described by Kolnai. That is, those who participated in wrong-doing no longer had a conscience that was informed by longstanding consensus and that has at its heart an aversion to killing. Instead, conscience had become overlain, moral absolutes no longer being respected and adhered to, but rather replaced by aberrant ideologies and political systems. Lagerway (2004) supports this position, and argues that it is essential to recognise and cease dangerous propensities such as the marginalisation, dehumanisation and isolation of the others that are common features of the loss of proper morality.

So then, although a sense of responsibility is important,<sup>85</sup> of more importance than this are the ethical principles that guide society and within this, nursing practice. The most significant change in Nazi Germany was the political ideology that became an accepted norm. Once this happens, then any act sanctioned by the political ideology becomes justifiable. If this argument about overlain conscience being the true villain of nursing's Nazi history is accepted, then the nursing code of conduct as it stands prevents atrocity, because patients are to be cared for, safeguarded from abuse and nursed with competence. Conscientious objection as described by Catlin, or as is promoted by the American Nurses' Association is not a necessary addition to make sure of this.

This is not to say that responsibility is unimportant. But there is more to grapple with on this issue because responsibility isn't so easily defined. As the section on moral responsibility in the Stanford Encyclopedia of Philosophy (2009) points out, philosophers are not always in agreement about what responsibility means. To begin with, it will be argued that conscientious objection can in itself also be an abdication of responsibility.

#### Conscientious objection can be an abdication of responsibility.

Before continuing, it is important to reiterate an earlier point. There is a risk in responding to these propositions, that a 'straw man' could be introduced and therefore it is important to clarify the position of this thesis. This thesis does not

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<sup>85</sup> As shall be shown, my position does not lead to improper loss of a sense of responsibility,

suggest that conscientious objection is wrong under all circumstances. On the contrary, my argument is that the nursing code of conduct ought not have a clause that directs nurses to conscientious objection as a choice or responsibility when they are ordered to participate in 'futile' care. The law already offers protection for nurses to avoid participation in abortion. Under particular conditions, individual nurses might refuse to carry out a doctor's order. However, this ought to be an individual decision where the nurse faces consequences as an individual. The NMC already sanctions that nurses can withdraw care under abusive conditions, and this includes illegal acts. That is, the nurse can refuse to carry out orders under extreme circumstances. The situations that cause moral distress that have been addressed by Catlin, also expose the nurse to extreme conditions in so far as she is exposed to trauma and suffering, but this is not equivalent to the act of killing, and despite the ethical uncertainty around this type of care, for now society has by consensus deemed it to be right.

To return to conscientious objection then, seemingly supporting Steppe's position on obedience, Staub (2003) carried out empirical research to determine the factors that influence a person who witnesses atrocity. She wanted to identify why some people passively stand by and watch an atrocity occur such as mass killings in Rwanda, and why others intervene to stop such occurrences.

She observed that bystanders, who do not become involved, fail to influence events in a positive direction, and thereafter tend to end up becoming more like

the perpetrators; they lose a sense of concern for the victims and can even become actively involved with the perpetrators.

Like Steppe, she observed that overly strong respect for authority with a predominant tendency to obey authority, was a feature of bystanders. However, as was argued in relation to Nazism, it should be noted that this is not a respect of authority as it occurs in legal clinical practice where individual decisions are made and care carried out in a professional and transparent manner. Rather, as already has been discussed, this was respect for a political authority that exists in a monolithic culture. It also tends to coincide with a sense of superiority where the other is seen to be somehow inferior to the perpetrator or bystander.

Staub's work points out an important feature. Bystanders who observe atrocity are not necessarily actively or intentionally causing harm. It is true that some of these bystanders could be silently encouraging the continuation of harm and lack the 'courage' to participate themselves. However, some of these bystanders must also be conscientious objectors: they judge the acts as harmful, they choose not to participate and in so doing protect their sense of integrity and autonomy. As hard as it is to consider that this is the case, one must remember that conscientious objection has as its central tenet, the protection of self. Whether or not the bystander disapproves of or doesn't disapprove of the actions they observe, each only serves to allow atrocities to continue. It is perhaps ironic to note that the emotional detachment from victims that tends to follow seems similar to responses in moral distress, where the nurse detaches from her patient either emotionally, physically or both.

This perspective shows that conscientious objection can in itself be an abdication of responsibility and this perhaps is the most serious negative consequence of Catlin's position. The nurse who is morally distressed can choose to conscientiously object to either medical treatment that is justifiable to the patient or else it could be that she conscientiously objects to medical treatment that is unjustifiable. Conscientious objection under Catlin's conditions is so self-focused, that there is no consideration of what the nurse is to do in actual harm, and indeed no guidance is given as to how she is to distinguish between these two states. By conceding to constraints such as lack of authority, emotional disturbance and risk of censure, there is a risk that the nurse will not fulfill her obligations to patients under harmful conditions. It seems then that conscientious objection on its own is not good enough under such circumstances. There is a requirement for nurses to act and conscientious objection is essentially a passive response.

To explore in depth the actions that the nurse is obliged to take once real harm is identified is beyond the scope of this thesis. However, the nurse under such conditions ought not to carry out the doctor's order. This is not a matter of conscientious objection. It is rather an act of disobedience that is required to protect the patient. Support for this position can be found in military law where soldiers are not protected from blame should they follow illegal orders.<sup>86</sup> Essential to this framing of disobedience rather than conscientious objection, is that it is not a reflection of individual perspective, but rather, takes legal and

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<sup>86</sup> See chapter three.

professional sources as the standard by which to judge. It is not the individual nurse who would take this stance, but the nurse as member of a professional body who acts in the same way as other reasonable professionals would also act. It confers on the professional a responsibility that extends beyond one's self and that does not allow the professional to excuse themselves from this responsibility. Childress (1985) has argued for the rightness of disobedience under illegal or frankly immoral circumstances and of course, the aim of disobedience is not self preservation but change of the circumstance to which one disobeys.

When the nurse perceives harm that does not reach this level of certainty, as when doctors continue to treat patients who the nurse believes to be better off dead, her responsibility and obligation is to accept medical orders but to continue to assess and advocate for the patient, to carry out clinical procedures competently and to emotionally and physically engage with the patient to ease suffering. These obligations have been shown to be important to patients (Halldorsdottir, 2008; Liu et al. 2005) and nursing professionals (de Araujo & Zoboli, 2010)

#### The nature of harm in moral distress and how it is to be resolved.

At the beginning of this thesis I set out to identify the nature of harm that is inherent in moral distress when nurses are faced with medical 'futility'. It was essential to identify if nurses were failing to address a primary harm to the patient, as empirical work seemed to insinuate but did not address in normative



resolutions. It is understandable that nurses experience moral distress when faced with these cases because they are not morally certain. As has been acknowledged, moral truth is not so easily accessible, and moral agents can only do their best to reach and respond to this truth. It has also been acknowledged that although consensus is important in identifying right action in medical 'futility', and the nurse is an important voice in this activity, the doctor carries authority for final decision-making. Given that direct harm to the patient<sup>87</sup> has not been identified, the question of whether or not there is any form of harm in moral distress needs to be addressed.

As Austin et al. (2005a) have indicated, resolutions to moral distress require both institutional and educational input. However it also requires recognition of the form of wrong-doing that happens in moral distress. It seems that this is not a primary wrong done to patients, but is rather, wrong done by the doctor to the nurse. Other than that, harm is done to nurses as a direct result from their proximate exposure to traumatic circumstances. Such events are no-one's fault, but they are inherent in the business of living and dying and can't all be alleviated by human endeavour: by nursing or in medicine.

This conclusion is in some respects rather surprising, but is supported by the empirical evidence and indeed it is supported by some current changes in military training. The nurse who identifies her actions performed under orders

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<sup>87</sup> Here I do not include the harm such as withdrawal of the nurse or nurse turnover, because as was discussed in chapter one, the empirical evidence has shown that nurses also can make more effort in their care, thus benefitting patients.

as torture, or 'futile', or unjustifiable is harmed when she continues to perform those actions. It also has to be understood that the nurse who carries out doctors' orders to a degree loses time and attention from doing the basic caring tasks that are also essential to good patient care.<sup>88</sup> Her sense of personal and professional integrity is damaged and contributes to significant harmful emotional reactions such as burnout and compassion fatigue. Although authors imply that the lack of authority and constraint that the nurse experiences in moral distress is a form of harm<sup>89</sup>, in fact, it is not this that is wrong, but rather the lack of acknowledgement that this power difference exists and that therefore requires proper management. In order for this to happen both nurses and doctors need to change. It is improper management of the power difference that is the harm in moral distress and 'futile' orders.

Resolutions to moral distress have been presented and discussed in nursing literature. Education and inclusive interdisciplinary decision-making are seen as key factors in this. The fact that wrong is not done to patients in cases of moral distress, is evidenced by the fact that good communication between doctors and nurses and opportunities for ethical discussions significantly reduce moral distress or else are suggested as essential to its reduction (Erlin, 2001; Austin et al., 2005b; Schwezner and Wang 2006; Catlin 2008; Breslin, 2008;).<sup>90</sup> The problem is that the details of how this communication ought to be carried out is not specified (Hamrick and Blackhall, 2007) and details about what kind ethical reasoning ought to be included in education are also not specified. Perhaps

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<sup>88</sup> See p25 for evidence that shows nurses' frustration at this circumstance.

<sup>89</sup> This was discussed in chapter one.

<sup>90</sup> There was detailed discussion of these papers in chapter one.

because of the current learning objectives, at least some workshops have been shown to be ineffectual in lowering moral distress even though attendees might enjoy them (Kalvemark et al., 2007). Less well described or intervened is the spiritual dimension of moral distress, but again evidence for its causal element to the experience of moral distress can be found in the sense of meaninglessness that accompanies the experience (Ewing & Carter, 2004; Ferral, 2006).<sup>91</sup>

For the remainder of this chapter some interpersonal and educational resolutions will be offered that give explicit and specific guidance that contributes ideas to how moral distress might be resolved. Firstly, some consideration of the ethics of care will be made. Two authors on the subject offer perspectives that could be used to change inter-professional communication, but it will also be argued that each falls short because of the lack of acceptance of consequentialist reasoning. It will be argued that consequentialist reasoning is an important way for nurses to frame their ethical reasoning and reduce their sense of distress. Secondly, the moral luck paradox that has already been applied to medicine by Dickenson (2003) as a method for reducing an overburdened sense of responsibility for doctors, will be shown to have some purpose for nurses too. All of these have educational significance. And finally, some consideration will be given to the spiritual aspect of moral distress.

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<sup>91</sup> Resolutions to moral distress as described in empirical papers were discussed in chapter one.

### Justification for the use of ethics of care

In previous chapters the proximity to the patient, emotional involvement with the patient and a frustrated need to ease suffering has been shown to be a key element in moral distress. I have chosen to examine the ethics of care because it is a form of ethics that takes a partialistic stance, that emphasises relationship and in Slote's (2007) view, takes empathy – an emotional and not necessarily rational faculty – as its foundation. This validation of the role of emotion in morality echoes my earlier interest in Solomon's writings. Further to this, the ethics of care has received a lot of attention in nursing academia<sup>92</sup> and has been promoted by some as the most appropriate ethical framework to inform nursing (Chambon & Irving, 2003). Slote (2007) and Koehn (1998) both offer interpretations of the ethics of care that are, it will be argued, helpful to the resolution of the harm moral distress exposes.

### The ethics of care

Gilligan (1982) carried out research that showed that girls and boys approached moral problems differently. Whereas boys had a tendency to approach such problems with a universalist paradigm such as deontology or consequentialism, girls tended to take into account aspects of these problems that were overlooked by boys and that were dependent on particular circumstance and relationship.

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<sup>92</sup> Although some care ethicists might be inclined to disassociate professional nursing care from the ethics of care (Koehn, 1998).

She proposed that a female ethics was distinct from the 'top down' approach by the predominantly male philosophers who had dominated the field. Researchers have developed the ideas of Gilligan.<sup>93</sup> Slote (2007) argues that this partialistic and sentimental (that is involving feeling and relationship) ethics was begun by Hume. Nordvedt (2011) following a nursing conference on the ethics of care summarised it as an approach to ethics that perceives humans as interdependent and that this interdependency makes us vulnerable. Indeed, Cronqvist (2004) points out that nurses are made vulnerable similarly to the way in which the patient is vulnerable and need emotional support.

The ethics of care is not without controversy and some question its validity as a complete framework for ethical decision-making (Edwards, 2011;). However, for this work, it will be assumed that there are authors who have made good analyses of the ethics of care and its usefulness in nursing (Nortvedt, 1998; Edwards, 2009; Sawatzky, 2009, Nortvedt et al., 2011; Nortvedt, 2011; Vanlaere & Gastmans, 2011) and my aim is to show how the two chosen authors perspectives can be applied to the problem of moral distress: the ethics of care is useful because it helps in this domain. Furthermore, it has been shown that nurses who apply ethics of care style reasoning are more likely to suffer moral distress than those who do not (Nathaniel, 2006). Therefore identifying possible gaps in the ethics of care is essential to helping nurses to resolve their distresss.

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<sup>93</sup> Noddings (2003) has also been an early influential writer in this field and has applied theory to subjects such as education.

Slote defends the idea that morality and moral reasoning can be based on the concept that empathy could be identified as the source of our moral frameworks and norms. His work echoes the conclusions that were reached in chapters one and two about the necessity of emotion in morality. I will argue that he also gives some explanation about the existential challenges that nurse's face in their care, although he did not have this as a intention in his work. He argues that deontology can be applied to the ethics of care to avoid a relativist foundation, but he rejects the inclusion of consequentialism.<sup>94</sup>

Koehn offers some practical resolutions to the issue of moral distress as she argues for a care ethic based on principles that again might offer some resolution to moral distress. However, she like Slote, avoids any consideration of the part that consequentialism might play in health care.

#### Slote's (2007) ethic of care.

Slote accepts that an ethic of care involves the identification of moral actions on the basis that an act is permissible if it exhibits caring on the part of its agent. (p10) He aims to demonstrate that the building and sustaining of relationships involves an ethical principle that 'takes us beyond the usual distinction between egoism and altruism and thus transcends what is strictly moral' (p12) He argues that empathy is the basis of morality – that it is this rather than reason alone, that offers at least our intuitive grasp of right and wrong, and that in combination with reason, it is at the base for moral understanding. He defines

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<sup>94</sup> Slote has already had some attention in nursing literature (van Hooft, 2011).

empathy as 'feeling someone's pain rather than feeling for someone as in pain' (p13) He accepts Hoffman's position that the feelings or thoughts of the agent seem more associated with the situation of the person empathised with than to the agent who is empathising. He describes his ethic as 'empathic caring' (p16) He argues that he sees that ethical debate can rest on empathising with a player in a situation and then defending this player by making him visible (p 17). He relates this idea to abortion, but this could alternatively be applied to the role of advocacy in nursing<sup>95</sup>. The proximity to the patient means that the caring nurse is likely to empathise with a patient's reality more than the doctor or other HCPs.

He notes that spatial distance has an impact on empathy. His interest in this issue is in the exploration of ethical issues around helping or harming those who are at a distance and not necessarily in direct perception of the moral agent. However, this idea of spatial closeness and empathy, echoes the findings I discussed in chapter one, where it was found that the proximity of the nurse to the patient increased her sense of moral distress. Perhaps Slote's idea further informs the problem of moral distress because he makes clear that the nurse's perception of moral reality is going to be heavily influenced by the greater empathy that she has with the patient. Where others have stated that the nurse differs because the nurse sees the suffering of the many and the doctor the saving of the few, perhaps this could be taken further, in so far as the nurse experiences the

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<sup>95</sup> The nurse as patients' advocate has been seen to be a central role of nursing and has had attention in nursing literature, sometimes in historical development of the profession, (Mallik, 1996) and has largely been individual patient focused, (Hanks, 2010) although recently Paquin (2011) has suggested that nurses ought to extend beyond the individual to social justice.

suffering of the many, and because she is closer to this suffering, exists in a different moral realm to the doctor, beyond a simple calculation as above.

The ethics of care is usually lacking in universal principles and Slote argues that empathy and care, to be released from the potential harm of relativism, need to be constrained within a broader and universal ethical code, and expresses a preference for deontological constraints on action. He argues that empathic intuitions are at the basis of norms such as do not kill.

I agree that universal codes are essential to the practice of morality, as has been previously discussed. Deontology offers a good explanation of this, because it ensures that some actions will never be performed because in and of themselves they are wrong. Presumably this protects people from atrocity being performed under seemingly caring intent and behaviour, as was described earlier in relation to nurses who euthanised patients under Nazism.

Indeed, as has been shown, once the nurse is sure that a medical order does not contravene laws and is an action that is by consensus agreed to be acceptable, the reverse also becomes possible; she can continue to approach the patient with caring intent and behaviour even though she is unsure about the rightness of a medical decision. This perhaps can be one resolution to a difficult psychological state that is moral distress

Slote then validates the concept of moral distress, if it is to be understood as I think it ought to be, as largely an empathic response to a patient under one's



care. Indeed he points out that 'perceptual and temporal immediacy' (p27) will result in a stronger empathic response to an individual in need than if one does not directly observe the suffering of such an individual. Interestingly he argues that such closeness offers good reason for partialistic responses to moral problems so that those who are near (and dear) are more deserving of our sense of obligation and helping actions than those who are not so near (and dear). This argument supports and perhaps gives reason for the empirical reports that were discussed in chapter one, where it has been found that the proximity of nurses to patients increases their sense of moral distress. Nurses, and particularly those that are empathic carers, are going to be exposed to the negative consequences of medical care at much closer proximity and over a greater time, than are the doctors who prescribe medical care and then move onto the next patient, ward or meeting.

#### Koehn's (1998) ethics of care.

Koehn (1998) as would be expected describes the ethics of care, actually feminist ethics, as an ethics that takes the self to be relational rather than as an individual. As with Slote, she points out that it rejects universal principles that apply to all situations in a personally detached way. In the ethics of care rather, there is an acceptance of differences between people and life histories. It is active and seeks to make a caring and trusting world by being caring and trusting (p5-9)

Similarly to Slote in so far as she wishes to ground the ethics of care in a non-relativist paradigm, she argues that the various models of ethics of care -

empathy ethics and trust - lack guiding principles and can end up in self righteousness, or can be manipulative or harmful to the carer, or to the person who receives the same. She argues that they lack any vision of the human good that make us capable of organising our lives into a meaningful whole (p15). She points out that an overwhelming and constant caring open attitude has no way of reacting to violence or imposing law on others. She supports the idea that an ethic is 'a reflection upon the conditions for shared and satisfying human living in a community in which human beings have differing perspectives on what qualifies as a good and satisfying life' (p27) and as such believes that the ethics of care does offer something unique. This stance further supports the necessity for nurses to take legality and proper professional practice as the fundamental principle from which they make decisions about medical care.

Interestingly she points out that it bases itself upon the subjective desires, whims and needs of the cared-for and care giver (p40-41). This is supported by Crisp's (2008) discussion about nature of compassion, where he points out that compassion might be felt for a person in the right way and at the right time, but not to the end of sharing and alleviating suffering of the other, but rather, through the 'self satisfaction one achieves through reflection on how kind one is being' (p242). Such a response argues Koehn, can tend not to open itself to self suspicion; that there is no Socratic *daimon* nor any warning regarding pride and *hubris*. This illuminates some of the problems with nursing academia where the promotion of the nurse as autonomous practitioner could be accused of being a vice such as pride. Pride could also be the source of moral distress where for example, the nurse strongly believes she knows the right thing to do, even

though she won't carry full responsibility and potential for blame that doing that action might bring. In addressing the fact that the carer can be abused or faced with manipulative wrong-doing she states that she wishes to reclaim autonomy and 'selfishness' (p44) from the relational aspect of caring. This reclamation and feminist stance in the ethics of care has, as I have previously discussed, been a strong influence in the development of the nursing profession.

She describes the ethics of care as primarily as an ethics of listening to the perspective of another. Again this echoes Slote's view, although he goes further in the identification of empathy, which does not just listen, but shares experiences and emotion with the person on the receiving end of care.

In order to ground the ethics of care in a more principled way she argues for a 'dialogical ethic' where the starting point is to admit that all people are prone to making errors and that through dialogue we are capable of using dialogue to better identify truth and distinguish it from error. She proposes that this does not mean that there is no truth or that we are always in error but rather, that we are capable of using the truth to identify error. She wishes to step beyond the totally partialistic stance of the ethics of care as originally conceived, where the ethics of care had not identified the good beyond expressing actions that are *motivated* (my italics) by care (p27). It is not necessarily convincing that one can arrive at moral truth by dialogue, but Koehn believes that this truth can be identified via a dialogue where it is recognised that some points of view are more valid than others.

Koehn's dialogical ethic concentrates on active listening but again similarly to Slote she makes a point to reject consequences from her ethic. She wishes to balance the human reality of ethical decision-making and wishes to avoid a 'God's eye' application of principles (p100) However, she wants to conserve principles that avoid this kind of certainty, that avoid the problems that arise with relativism, and that assist with ethical decision-making within context. She promotes the search for truth through active listening.

Koehn presents four new principles that act as a foundation for dialogue. They are she believes more 'supple' than those in deontological or consequential paradigms. The first is to recognise that some reasons are better than others. She argues that people ought to be thoughtful doers and thus subsequently argues for the rightness of debate. Within this best reasons for acting are established. It is teleological because she proposes that we should live the examined life and this means that within ethical decision-making, all people ought to be open to challenge, questions and fulfill the obligation to justify their actions. Within this principle it is important for moral agents to admit that they might be wrong. The second and third principles are to act justly and to obey laws that a community has agreed to obey. Finally, she argues that the moral agent or community ought to remain open to questioning and ensure that they have truly met principles one to three (pp100-149).

## The Ethics of Care and how it helps to resolve moral distress

Both of these authors offer an ethical perspective that when combined offers some help in finding a resolution to moral distress that allows the nurse to carry out medical orders that she might initially disagree with, with a clear conscience and whilst remaining close to the patient.

Firstly, Slote makes it clear how important proximity is to creation of an empathic response to persons, and in the case of nurses, to the patient. Indeed, without proximity, empathic response might be more difficult to sustain, and if empathy and the care that stems from it is to be a valued characteristic of nursing, then the doctor has a responsibility in ensuring that this facet of nursing is preserved as much as possible, by not removing her from caring activities unless it is justifiable and of course by giving her justification for actions.

To acknowledge this responsibility of the doctor requires two things. Firstly the doctor has to recognise and respond to this responsibility. But secondly, and prior to this, the leadership role of the doctor has to be recognised by both the nurse and doctor. The fact that doctors have authority to direct nurses' actions is not readily acknowledged in nursing literature, and although it seems that doctors, lawyers and the rest of society acknowledge this to be true, doctors and nurses seem to keep silent about it. For example Cohen and Erickson (2006) discuss how the nurse has moved from the group of 'women who carried out basic tasks for the sick and the ailing' to the professional who has the education and responsibility to make complex clinical decisions who :

‘Although they may function independently.....nurses also collaborate with many other members of the multidisciplinary team’ (p775.)

Although I do not mean to suggest that collaboration is an unimportant facet of nursing and medical care, the identification of collaboration also falsely implies a relationship of equal authority. Indeed when considering medical care that requires a lot of nursing input, and this care often involves aggressive medical treatment at the end of life, the relationship ought to be considered as tripartite: doctor: nurse : patient. In the medical ethics literature the doctor : patient relationship is almost exclusively referred to, and the nurse is often absent<sup>96</sup> Peter and Liashenko (2004) point out that that proximity is an important feature of moral distress, but this proximity is also to the doctor. In the words of Liashenko (1994) this proximity is so close that the nurse is the eyes and ears of the physician. This dependence of doctors on nurses is absent from all the papers that discuss the doctor - patient relationship.

There have been moves over recent years for doctors and nurses to come together in inter-professional education and this is a good thing, (Barrow et al., 2011;) <sup>97</sup> As has already been discussed, good inter-professional communication is important to the reduction of moral distress, and empirical research confirms that this is essential to good patient care and outcomes, but even now still does

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<sup>96</sup> Nursing ethics on the other hand frequently has reference to the doctor, but again analysis is made of the nurse: patient relationship.

<sup>97</sup> But it is not without its problems, such as the large numbers of nurses in comparison to doctors.

not work as well as it should and leadership can be lacking (Weller et al., 2011).<sup>98</sup>

How then is the dynamic between doctor and nurse to be nurtured in such a way as to reduce moral distress thus allowing the nurse to continue to care?

Koehn's theory makes clear the importance of dialogue in coming to moral truth and from a medical perspective, in making patient care decisions. Most important in her thesis is that in dialogue, in order to truly listen to one another, agents must approach the 'truth' with an acknowledgement that one's own view might be wrong – this is a form of humility that is beneficial to HCPs. It echoes Kolnai's work on the erroneous nature of conscience and his statement that:

'Conscience that cannot hope to be correct , and ....cannot fear to be erroneous, is not Conscience'(p179)

It also reflects the stand taken by Murray (2010) who argues that nurses need to be morally courageous whilst avoiding the error of moral arrogance or certitude.

Moral arrogance is the belief that one's own point of view is the only right view in situations that are morally controversial and where others might hold different moral opinions (Gert, et al., 2006) whereas morally arrogant individuals are condescending and dismissive of the thoughts of others, with an interest that does not go beyond the self (Baylis, 2007). The nurse who thinks

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<sup>98</sup> It should be noted that sometimes the properly trained nurse might offer better leadership of medical procedures under specific conditions than a junior doctor. (Gilligan et al., 2005) But in moral distress, the nurse necessarily doesn't have this authority to lead.

she knows what is best to be done, even though she doesn't carry full responsibility for that act is like the doctor who thinks he knows best and refuses to see the perspectives and needs of the nurse who allows him to carry out the act that she does not have authority for, but shares responsibility for. Both could be accused of moral arrogance and lack of humility which is the opposite.

Humility is not commonly spoken about in nursing or indeed medicine, but may have a part to play in proper communication. The doctor has a responsibility to listen to the nurse, to acknowledge that his view might not be the best view. Likewise, the nurse has a responsibility to listen to the doctor, and eventually, in legal circumstances where gross misconduct is not occurring, she can be free to accept his decision as right. This freedom to accept the doctor's final decision as right is essential to the nurse's ability to continue to nurse her patient; that is to deliver the medical orders but also to deliver the basic cares that are so important to nursing practice. So long as this dialogue is ongoing, then the nurse is also free to continue to act as patient advocate, to assess changes in patient status and perhaps influence decisions at a later point.

Within this dialogue and in acknowledgement of the authority of the doctor over the nurse, it is essential that the doctor assume responsibility for justification of his decision; as Koehn argues this is an important part of dialogue. Further support of the success of this approach can be found if recent trends in military training are examined.



In the Second World War Marshall (1947) observed that many soldiers did not fire their guns when faced with situations where they had to defend themselves, but where this defence would result in killing. This demonstrated how difficult it is for soldiers to kill and how deeply the moral sense of wrong-doing extends in the human psyche. Military training has tended to encourage dehumanisation of the enemy, so that the act of killing can become more acceptable, because soldiers could identify their actions as being directed towards sub humans and therefore more permissible. However, as Evans (2011) discussed in a programme broadcast on Radio 4, many military centres in the UK and US no longer dehumanise the enemy, but rather, provide the soldier with proper justification for going to war and killing. Such justification is designed to justify actions, but in so doing protects the soldier from breakdown of a sense of integrity and moral identity that can be extreme.<sup>99</sup>

Doctors can perhaps benefit from consideration of this form of training and how it reflects what happens to the nurse who is asked to carry out an order that she believes to be harmful to the degree that she identifies as wrong. Although killing is not the same as aggressive treatment, if the nurse perceives herself to be 'torturing' or 'flogging' a patient the difference is perhaps not as great as it first seems. This requirement for listening to and justification of orders already exists in the American Medical Association's (AMA, 1994) code of ethics:

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<sup>99</sup> Kilner (2011) was a soldier ethicist who contributed to the programme and keeps a blog that details discussion on this and other issues.

‘One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to hear the nurse’s concern and explain those orders to the nurse involved. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice.’ (Opinion 3.02 Nurses)

but is not present in the GMC code or in nursing codes. Furthermore, an individual approach to listening and justifying action, although essential, is not sufficient. Medical policy decisions in individual institutions also ought to involve nurses; listening to the nursing perspective when policies such as early neonatal treatments or other crucial policies such as the character of ‘do not resuscitate orders’ must also include nurses. Indeed, perhaps it is time for nurses and doctors to be guided by a single code of conduct to ensure that this communication is inherent in each profession from the start. Pattison (2001) provides some support for this stance and argues that universal principles could be identified as a foundation for all health care codes of conduct in order to provide coherence of professional duties and expectations. Further to this it is interesting to find that the allied health professions in Australia already have a

body of universal standards from which each individual profession develops standards specific to their profession.<sup>100 101</sup> (ACT Health, 2004)

In addition to this, it is important that nurses are asked to carry out orders that are consistent for similar patients no matter who the physician is. For example. Seale (2010) found that doctors of faith gave less deep terminal sedation than doctors of non faith. Beckstrand and Kirchhoff (2005) found that nurses identified inconsistency between doctors, as a significant obstacle to good end of life care. It is difficult for nurses to justify care if different consultants approach similar cases differently, and doctors ought to work to gain more consistency because this is also an important form of dialogue and facet of justification for orders.

Finally, the closeness that is essential to empathy and that is fundamental to Slote's understanding of care, is a feature of nursing practice that deserves greater attention. The suffering of patients and proximity to that suffering also causes suffering for HCPs (Sulmasy, 2006) and perhaps particularly the nurse. Indeed Maeve (1998) describes how nurses can be seen to go beyond empathy to a state of embodiment, where nurses don't just imagine the experience of the other, but directly share it, to a degree at least. This embodiment is a significant aspect of being with the other, that is a central meaning of nursing. Doctors also are vulnerable and suffer as a result of medical care of patients (Aase et al., 2007)

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<sup>100</sup> The allied health professions include, among others, dentists, veterinary surgeons, physiotherapists, chiropractors and dental hygienists.

<sup>101</sup> In the UK allied health professionals are members of the Allied Health Professionals Federation, that exists to promote interprofessional working, but it doesn't go so far as to set generic standards. (ACPF, 2011)

but Agledahl et al. (2011) have found that a feature of medical practice is that it tends to remove doctors from consideration of the existential challenges of patients.

From this it is surely reasonable to assume that this lack of existential curiosity extends to the nurses who carry out so much care on behalf of the doctor. Mutual care for and consideration of colleagues is another way in which moral distress could be relieved. Indeed, for the nurse who is too worn out to continue to care for her patient, rather than conscientious objection, the care of another nurse who offers to step in and to care for that patient is surely a better way forward in cases of moral distress. Or the nurse who feels too exhausted to give the next antibiotic or suction to the critically ill patient, perhaps for a period the doctor can offer to stay and give some of this care, or help the nurse with another task. Such mutual care has been demonstrated between members of the same professional group (Aase, 2008) but perhaps more support could happen between professionals of different groups.

So far then, Slote and Koehn help to provide some explicit reasons and methods of communication and behaviour that ought to exist between doctor and nurse, and that ought to allow the nurse to continue her work without being overly burdened. However both theories fall short in so far as they fail to recognise the importance of a consequentialist stance in offering further rational responses to 'futile' medical cases and moral distress. Although some of what has been written already in this chapter involves spiritual understanding of moral distress, it

seems that consequentialism and spirituality might together offer some sense of distance from the immediacy of moral distress and that might help the nurse.

The necessity for consequentialist and spiritual understanding in the resolution of moral distress.

Medical decision-making relies on universal concepts and rules. In the case of clinical medicine, prescribed care relies upon previous research and predictions based on this research. Likewise in the case of ethical decision-making rules and principles also need to be followed. Although medical ethics includes discussion of many ethical modes of thought such as consequentialism and deontology, in practice, the professional codes of conduct tend to offer a deontological approach to care. Nurses are required to do no harm, to act in the best interests of the patient (Beauchamp & Childress, 2001), to promote the dignity of patients (Jackson & Irwin, 2011; Condon & Hegge, 2011; Mathews, 2010; Kalb, & O'Conner-Von, 2007; Castledine, 2006) to be compassionate (Georges, 2011; Davison and Williams, 2009; Hem & Heggan, 2004). Sometimes the practice that addresses such valued forms of care can be easily identified, such as treating all patients equally (Lin & Tsai, 2011) However, to define each of these can be difficult in themselves and in ethically challenging situations, (Manthorpe et al., 2010, Milton, 2008; Wainwright and Gallagher, 2008; Haddock, 1996; van der Cingel, 2009), and where the definition of what action ought to be performed requires some prediction of consequences of actions. This is further problematic given that we cannot predict the consequences of actions for each individual patient, as research data deals with populations.

For example, Chambers and Ryder's (2009) work on compassion and caring describe caring and compassionate attitudes, but it is impossible to quantify what this means in one case and then the next. So for example, the patient who is acknowledged to be dying has their dignity preserved by good palliative care. The same patient who is not acknowledged to be dying has their dignity preserved by attempts to save life. Perspectives of doctors and nurses on these cases will differ, and if the nurse is to find any solace in facing one failed case of medicine after the other, the only way she can achieve this is by consequentialist reasoning.

The empirical work that medicine is grounded in and that justifies aggressive medical treatment was discussed in chapter four. It is essential that nurses are given access to such information so that they can have a sense of justification for their actions. The fact that the nurse can know that some patient somewhere is being saved by the treatment she observes as failing, gives her a broader perspective that proximity and involvement with the patient in front of her does not allow for. How this knowledge is given is open to interpretation. It could mean being invited to institutional clinical meetings, it could mean that the nurse occasionally leaves one ward or unit to visit another where her surviving patients have been discharged to. It might mean that doctors offer follow up information to nurses weeks after a patient has left and has attended out patients. This position is supported by Hamrick & Blackhall (2007) who suggested that nurses observed higher frequency of 'futile' situations than doctors because doctors left ICU and had more varied activities.

Dickenson's (2003) exploration of moral luck might also offer the morally distressed nurse some solace. She describes the difficulty in making moral choices because predicting outcomes of acts cannot be achieved with certainty because all events are affected by luck (pp46-64). As was discussed in chapter four, it is not possible to predict with certainty who will die and who will not under conditions of aggressive medical care. The nurse who accepts that she is not able to predict with certainty the outcome for an individual patient, even though her fears might be realised, can let go of a sense of blame and regret. This acceptance that she does not have a God like ability to predict the future, can also alleviate the experience of moral distress. It is perhaps another form of humility. Dickenson does not link her examination of luck and consequences to spirituality but it seems to me that there is overlap, if concepts such as humility and forgiveness are accepted as spiritual acts and relevant to this letting go of a sense of total control.

Forgiveness has not been discussed in the field of moral distress but is perhaps another activity that ought to be considered in health care practice and indeed has been shown to increase well being in patients has been demonstrated to have effectiveness..<sup>102</sup><sup>103</sup> The nurse who sees the patient who dies after aggressive and what in retrospect could be described as futile care, needs to let

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<sup>102</sup> Griswold (2007) has made a philosophical exploration of forgiveness that offers in depth analysis of the benefits and nature of forgiveness.

<sup>103</sup> Forgiveness has attention as a clinical intervention in psychiatric care, but not as an intervention for HCPs to better cope with emotional difficulties such as moral distress (See for example Vitz & Meade, 2011; Braithwaite et al., 2011; Worthington et al, 2007)

go of the sense of blame and regret that can also be burdensome. That forgiveness can be a freeing feature of her experience requires the doctor to acknowledge the difficulties she has faced in responding to his orders. As a matter of care, it is perhaps important for the doctor to say sorry for the suffering and distress that both patient and nurse have experienced in the delivery of medicine. This is not so much an admission of blameworthy action, but is rather an admission that medicine often fails and that harm is intimately entwined with its ability to benefit. This again is a term and activity more commonly placed under the subject of spirituality.

As was shown in chapter two, Solomon examined emotions and morality in his early career and it is interesting to see how his work developed to include the importance of spirituality in ethics, even though he was atheist (Solomon, 2002). In my own analysis of moral distress the questions that are inherent to spirituality also seemed to be central to its resolution. Authors have discussed the importance of finding meaning in moral distress in the face of suffering (Meiers & Brauer, 1998; Gustafsson, 2008) and although most of the attention in the work on spirituality and meaning has been directed towards the nurse helping the patient to find meaning (Balboni et al., 2010; Edwards et al., 2010; Deal, 2011; McSherry, & Jamieson, 2011).

Solomon argues that spirituality is 'coming to grips with the big picture and with it a larger sense of our lives' (p5) Again, this broader picture is essential for the nurse who is proximate to suffering. Rather than Dickenson's rather cold assertion that responsibility can be limited by an acknowledgement of luck,



Solomon asserts that instead, one ought to face the uncertainty with trust and to accept that whatever happens, is not wholly in one's own hands. Although he doesn't associate this with a belief in God, it is perhaps helpful to consider that religious teachings also encourage an acceptance of lack of control as a central act of faith. Whether its luck or God, no nurse or doctor has full control of what will happen to their patients. Perhaps this could be described as a caring and spiritually influenced consequentialism. With such a stance it seems to me that the competent and caring nurse who can accept this, can then accept that in the face of regrets and unwanted outcomes, that she did her best under the circumstances, or as Solomon states 'A sense of powerlessness combined with resoluteness and responsibility.' (p47.)

It is difficult to conclude how a sense of spirituality can be incorporated into nursing. Chan (2010) found that nurses who practiced a religion were more likely to provide for the spiritual needs of patients. It must be asked how in a secular society, can nurses gain a spiritual understanding of what they do? The potential answers to this question are varied and in this thesis there is only space available to give brief consideration to them. One approach could be to make practical consideration to nurses' work. For example, Maeve (1998) found that nurses coped with suffering by having time to clean the patient and surroundings after death. Sometimes service demands make it difficult to spend an appropriate length of time in laying a person out and giving them time to 'rest'. Inclusion of ritual around this kind of activity could help nurses. In busy environments where a death is quickly replaced by the next critically ill patient and where there is no time to engage in this kind of coping, then perhaps a book

of condolences or observation of a minute's silence could be incorporated into the ward's routine. An activity such as a minute's silence could be particularly beneficial because for a short time it joins all the members of the multidisciplinary team together in acknowledgement of what they do.

Another approach that might help with the spiritual aspect of moral distress is for further work to be carried out on how expectations impact on the experience. Gustaffson (2009) found that expectations had a significant impact on moral distress and burnout. It might be that nurses have unrealistic expectations about what they can achieve in their care. For example, the fact that nurses take doctors' orders is not discussed in nurse education, nor is it found in the nursing literature, other than as a point of advocacy or else as a wrongful power imbalance.<sup>104</sup> Without this acknowledgment nurses lose the basis from which to demand proper management in so far as they ought always to feel justified in the orders they follow.<sup>105</sup> The frustration that comes from not being able to make final decisions is worse if the nurse has been educated in such a way as to believe that she carries responsibility for these decisions. However, unrealistic expectations can also run into an overestimation of what nursing and medicine can achieve in the face of suffering. As Solomon argues, tragedy and suffering are insurmountable features of human life, and it is possible to overestimate the impact of medicine and nursing on the alleviation of suffering, especially towards the end of life. For example Gielen et al. (2009) found that around forty percent

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<sup>104</sup> The empirical and scholarly work that this is based on has been cited in previous chapters.

<sup>105</sup> Kane (2009) highlights the importance of discussion that leads to this sense of justification in HCPs who are involved with abortion

of interviewed nurses in Finland working in palliative care, were supporters of voluntary euthanasia as an alternative to terminal sedation. Although this might reflect a respect for patient autonomy at the end of life, it might also reflect the fact that palliative care eases suffering for many patients, but not for all. Supporting this position Verpoort et al. (2004) found that some of the nurses interviewed were supportive of voluntary euthanasia where suffering could not be alleviated and was intolerable to the patient. In accepting that nursing and medicine is not a cure all for suffering, the nurse is less likely to burden herself or the doctor with blame when things do not turn out in the way she would want.

### Conclusion

This chapter has opposed the objection that to exclude conscientious objection from the UK code of conduct could be associated with a lack of responsibility that leads to nurses allowing or participating in atrocious acts. It has broadened the basis from which solutions to moral distress might be found to include an acknowledgment of medical authority over nursing actions and the spiritual aspect of the complex experience of moral distress. In the epilogue the narrative that formed the initial ideas in this thesis will be returned to and a concluding analysis of moral distress in 'futile' medical care be made.

## Epilogue

This thesis has sought to understand the nature of harm that occurs in moral distress when nurses feel complicit in 'futile' care and to examine whether or not professionally sanctioned conscientious objection to 'futile' orders ought to be included in the UK (and other) nursing codes of conduct.

The nebulous nature of harm in moral distress was categorised as a primary harm done to the patient and a secondary harm done to the nurse, and indirectly to the patient. It was argued that moral distress does not identify primary harm to the patient. Illegal orders would be a primary harm, but this is not what occurs in moral distress. Moral outrage that requires a response of disobedience on the part of the nurse, would be the correct term to apply to this circumstance and choice of action. Indeed the choice in this instance is one of professional obligation, and not a matter of self-protection.

The nurse is a professional who necessarily works under the authority of the doctor, and to avoid a concession to this fact is a disservice to nurses. This state of affairs has been shown to be a matter of societal consensus with regard to the law, and philosophically is supportable. Professional codes differ in their response to this fact, but once the essential nature of nursing is examined, it is difficult to see how the nurse ought to be encouraged away from her patient's bedside under any but the most extreme circumstances. Should professional codes confer a sense of authority to the nurse with regard to medical decision-making, then the nurse is necessarily going to be frustrated.

The intention was to keep grounded in the practical reality of clinical nursing. In meeting this end I will consider how the narrative that was the initial analysis of moral distress, might change as a result of the completed analysis.

First of all, the events of the narrative would not be changed. Mrs Bird would most likely still be treated, unless perhaps if the nurse decided to advocate further for her, by directly calling the consultant in charge. However, if she had taken into account the importance of consensus, and the fact that her nursing and medical colleagues, other than the registrar, did not see medicating Mrs Bird as a misjudgment, then maybe speaking with the registrar was enough.

The nurse was correct in her prediction of consequences for Mrs Bird, but this prediction had been based on caring for one other end stage COPD patient a matter of a few days before. The events that this patient had experienced had been traumatic to observe, and although there is no doubt that this coloured the nurse's prediction, she applied sound reasoning to the concerns she expressed to the registrar. The emotional distress that she had experienced with this other patient acted to increase the emotionally distressing element of moral distress. The last time she had seen this patient she had avoided going into his room because she knew she could not ease his suffering. There had been no spiritual resolution of this failing and this added to the emotional distress. Some of the anger she felt must have been a projection of the anger she felt for this failing that was her own.

The narrative now appears to be flawed when it argues that the adherence to duty ought to be replaced by a limitation of sense of responsibility. This phrase carried with it the implication that the nurse could perform acts for which she was not responsible. This is an error because it psychologically detaches the nurse from physical actions and would lead to the breakdown of the sense of good conscience and the sense of integrity, autonomy and responsibility that are essential to nursing care.

Instead, the distinction between authority and responsibility needed to be defined. The nurse was responsible for all of her actions, but the authority to decide on Mrs Bird's care was the registrar's. Rather than accepting the registrar's conclusion that the consultant had made the decision and therefore it would be followed, the nurse ought to have required a reasonable justification for the prescribed medical treatment. The registrar ought to have been educated and worked under institutional directives that he was under obligation to offer this justification. The empirical data that the nurse did not have access to would have been an important feature of this justification. The registrar ought to have broadened the nurse's perspective beyond the two patients that crowded her physical space and mind. Thereafter, the nurse could have proceeded with the treatment and care with an eased burden. Although the traumatic aspect of care would remain, this justification would have removed the 'moral' from moral distress. The freedom to be physically and emotionally proximate to a patient is an essential feature of nursing, and the removal of the sense of wrong-doing may have allowed the nurse to remain more closely with the patient.

Although the narrative was correct to question the adherence to a sense of duty and the code of conduct, perhaps it failed to recognise that blindly following a code or any other directive is a form of overlain conscience. The lack of flexibility that this results in fails to recognise the complexity of moral and emotional responses to caring for sick and dying people. The nurse would have benefitted more from the partialistic and relational paradigm of the ethics of care in relation to her 'moral dilemma'. By doing so, the dialogue between her colleagues and particularly the registrar might have continued for longer. But perhaps most importantly, she would have accepted the offer of the charge nurse to put up the infusion for her. This was an example of care and compassion from a colleague, and the duty bound moralistic stance of the nurse failed to be open to receiving this care and compassion. The care that was offered touched the nurse, but perhaps had she have taken some help, particularly in putting up the infusion that had such unpleasant side effects associated with it, she might have been more able to remain proximate to her patient and would most likely not have felt the need to withdraw from her. An understanding that proximity colours the moral reality that one faces would have also helped her. She might have better understood that the emotions she experienced were part of that proximity and that as distressing as they were, they were also the source of compassion and good nursing.

In this instance and in all instances of 'futile' orders it is right that the nurse ought not to conscientiously object to a doctor's orders. It blurs the boundaries of authority and responsibility and burdens the nurse with a sense of authority that she is not by consensus deemed to have. If she does not concede to this lack

of authority, or else train as a doctor, she will always be frustrated. Such frustration will burden the nurse with a sense of doing wrong, and will necessarily take time and energy away from what ought to be the focus of her work: the nursing care of the patient.

Of course the response of the nurse to 'futile' orders, where the doctor orders care that is certainly harmful, or other instances of objective harm is another matter. This thesis has only examined the case that turned out to be an area of ethical uncertainty, where the nurse is always right to concede to medical orders, preferably under the ethical conditions I have proposed as antecedent to this. How she ought to prevent serious harm to patients is another subject, but one that this thesis certainly leads onto.

The recent cases of patient neglect that have highlighted serious misconduct on the part of the nursing profession only serve to further reiterate how important nursing care is. (QCC, 2011) Whatever the causes for these misdemeanors, they demonstrate the necessity for nurses to remain proximate to the patient – not only to deliver care, but also to be close enough to experience the empathy that is a source for ethical practice. It might be that the movement in nursing history to gain autonomy and to take on a sense of responsibility and authority for doctors' orders has contributed to this. If so, then a professional acceptance of the power difference between nursing and medicine might be an important step in nursing, because it means that nurses make themselves more free to nurse. In a society that will always prefer cure to care when that choice is available, this is perhaps



the best that nurses can do. Whatever the case, the patient must always be the object of first concern.

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